



P.O. Box 17
8127 Forch, Switzerland
Phone +41 43 366 10 72
Fax +41 43 366 10 79
E-Mail: dignitas@dignitas.ch
Web: www.dignitas.ch

Sender: P.O. Box 17, CH-8127 Forch
Health and Sport Committee, T3.60
Scottish Parliament
Edinburgh, Scotland
EH99 1SP

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**Proposal for an Assisted Suicide (Scotland) Bill (SP Bill 40)
as introduced in the Scottish Parliament on 13 November 2013**

**Response / Submission by DIGNITAS - To live with dignity -
To die with dignity, Forch, Switzerland**

This is the full version of DIGNITAS’ response / submission on the proposed Assisted Suicide (Scotland) Bill. Complying with the requirements set out in the call for evidence, a short version comprising not more than 2,000 words of the response by DIGNITAS is also submitted to the Committee.

DIGNITAS is very happy to give oral evidence if the Committee would wish.

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1) Introduction

“The best thing which eternal law ever ordained was that it allowed us one entrance into life, but many exits. Must I await the cruelty either of disease or of man, when I can depart through the midst of torture, and shake off my troubles? . . . Are you content? Then live! Not content? You may return to where you came from”¹. These are not the words by a protagonist of the many organisations around the world representing the interests of people who wish for freedom of choice in ending one’s life self-determinedly today, but the words of Roman philosopher LUCIUS ANNAEUS SENECA who lived 2000 years ago, in his letters dealing with moral issues to Lucilius.

In recent years, questions dealing with the subject of (assisted) suicide and euthanasia have arisen again and are now discussed in the public, in parliaments and courts.

Of the many reasons for this development, one is the progress in medical science which leads to a significant prolonging of life expectancy. In fact, even during the congress of the Swiss General Practitioners in 2011² this was an issue when it was emphasised that a sudden death, for example due to a ‘simple’ heart attack or a stroke is nearly unthinkable today, due to possibilities of modern intensive care.

Obviously, this progress is a blessing for the majority of people. However, it can also lead to a situation in which death as a natural result of an illness can be postponed to a point much further in the future than some patients would want to bear an illness. More and more people wish to add life to their years – not years to their life. Consequently, people who have decided not to carry on living but rather to self-determinedly put an end to their suffering started looking for ways to do so. This development has gone hand in hand with tighter controls on the supply of barbiturates and progress in the composition of pharmaceuticals which led to the situation that those wishing to put an end to their life could not use this particular option anymore for their purpose and started to choose more violent methods. A further, parallel, development was the rise of associations focusing on patient’s rights, the right to a self-determined end of life and the prevention of the negative effects resulting from the narrowing of options.

In the United Kingdom, as long ago as 1935 a Voluntary Euthanasia Society was formed in England and the year after, a Voluntary Euthanasia Bill was discussed in the House of Lords.

In Scotland, in 1980, the group “Exit” (at some time also known as Scottish Exit and VESS – Voluntary Euthanasia Society Scotland) was formed, followed in 2000 by “Friends At the End (FATE)” in Glasgow.

¹ In: Epistulae morales LXX ad Lucilium

² Congress of Swiss General Practitioners in Arosa, March 31st – April 2nd, 2011, see online: <http://www.arosakongress.ch>

In Switzerland, over 30 years ago, EXIT (German part of Switzerland) was founded, in the same year as EXIT-ADMD (French part of Switzerland), and shortly afterwards the first association to offer the option of an accompanied suicide to its members. Further not-for-profit member's societies like EX INTERNATIONAL, DIGNITAS, SUIZIDHILFE and LIFECIRCLE followed, the only difference between these organisations being mainly the acceptance or not of members residing in countries other than Switzerland. As a result of the above-indicated aspects and other developments in modern society, the focus of all associations has widened to include working on suicide preventive issues directly or indirectly, especially suicide attempt prevention.

Today, EXIT has 73,000 members, EXIT-A.D.M.D. over 19,000 and EX INTERNATIONAL approximately 700 members. DIGNITAS, together with its independent German partner association DIGNITAS-Germany in Hannover, counts over 7,000 members worldwide of whom over 800 reside in the U.K.³

In the over 16 years of DIGNITAS' existence, 244 members of DIGNITAS residing in the U.K. – of whom 10 lived in Scotland – have made use of the option of a self-determined ending of suffering in Switzerland⁴. For all members, being assisted and accompanied through the final stage of their life towards their self-determined end was and is an issue of major importance. DIGNITAS always encourages members to have their next-of-kin and/or friends at their side during this stage, as well as on their journey and at the accompaniment itself.

However, the present legal situation in Scotland, just as much as in the U.K. in general, has the appalling effect that this very important support towards the end of life must take place shadowed by the fear of prosecution, sometimes even leading patients to decide to travel only with very few loved ones or even alone. This effect, deriving from the current legal situation, can only be seen as a disrespect of human dignity. For England and Wales, the publication by the Crown Prosecution Service (CPS) of the “Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide” in February 2010⁵, sparked by the court case of DEBBIE PURDY, did not change this; in fact, it could not change the legal status quo as this authority simply does not have the competence to change the law – only Parliament can do so.

In Scotland, just as much as in the rest of the U.K., suicide as such is not a crime (anymore). However, assisting a person to commit suicide is: in Scotland one may be liable to be prosecuted for homicide, the decision being at the discretion of the Crown Office and Procurator Fiscal Service (COPFS). In England and Wales aiding, abetting, counselling or procuring the suicide of another or an attempt by another to commit suicide is a crime under the Suicide Act 1961.

³ <http://www.dignitas.ch/images/stories/pdf/statistik-mitglieder-wohnsitzstaat-31122013.pdf>

⁴ <http://www.dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2013.pdf>

⁵ http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.pdf

This legal situation is approached quite differently under Swiss law: whilst in Switzerland too, suicide as such is not a crime, article 115 of the Swiss Criminal Code states:

“Whoever, from selfish motives, induces another person to commit suicide or aids him in it, shall be imprisoned for up to five years or pay a fine, provided that the suicide has either been completed or attempted.”

The obvious difference is the ‘selfish motives’: whilst in Scotland and the rest of the U.K. the law basically threatens to punish assistance in suicide whatever the motive, Swiss law makes a clear distinction of motives, excluding assistance out of non-selfish motives, and thus gives a basis for assisted (accompanied) suicide – made possible by associations like DIGNITAS, EXIT and others.

DIGNITAS very much welcomes the proposal for a Bill providing a means for certain people who are approaching the end of their lives to seek assistance to end their lives at a time of their own choosing, and to provide protection in law for those providing that assistance: it brings the issue of end-of-life-questions to the level where it should be addressed, the legislation.

2) Article 8 § 1 of the European Convention on Human Rights (ECHR) and the right to a voluntary death

On March 8th, 1951, the U.K. ratified and later implemented in its law the European Convention on Human Rights, to which all European states now adhered (with the exception of Belarus and the Vatican). Since then, in specific cases, set legal situations may be questioned whether they would be in line with the basic human rights enshrined in the ECHR. However, according to its preamble, this state treaty is not only a fixed instrument, “securing the universal and effective recognition and observance of the rights therein declared” but also aiming at “the achievement of greater unity between its members and that one of the methods by which that aim is to be pursued is the maintenance and further realisation of human rights and fundamental freedoms”⁶. The ECHR is a living instrument and its text and case law need to be taken into consideration when raised in court cases just as much as in legislation.

In the judgment of the European Court of Human Rights in the case of *DIANE PRETTY v. the United Kingdom* dated April 29th, 2002⁷, at the end of paragraph 61, the Court expressed the following:

“Although no previous case has established as such any right to self-determination as being contained in Article 8 of the Convention, the Court

⁶ Convention for the Protection of Human Rights and Fundamental Freedoms, page 5, available online: http://www.echr.coe.int/Documents/Convention_ENG.pdf

⁷ Application no. 2346/02; Judgment of a Chamber of the Fourth Section, available online: <http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-60448>

considers that the notion of personal autonomy is an important principle underlying the interpretation of its guarantees.”

Furthermore, in paragraph 65 of the mentioned judgment DIANE PRETTY, the Court expressed:

“The very essence of the Convention is respect for human dignity and human freedom. Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity.”

On November 3rd, 2006, the Swiss Federal Supreme Court recognized that someone’s decision to determine the way of ending his/her life is part of the right to self-determination protected by article 8 § 1 of the Convention stating:

“The right of self-determination in the sense of article 8 § 1 ECHR includes the right to decide on the way and the point in time of ending one’s own life; providing the affected person is able to form his/her will freely and act thereafter.”⁸

In that decision, the Swiss Federal Supreme Court had to deal with the case of a man suffering not from a physical but a mental ailment. It further recognized:

“It cannot be denied that an incurable, long-lasting, severe mental impairment similar to a somatic one, can create a suffering out of which a patient would find his/her life in the long run not worth living anymore. Based on more recent ethical, juridical and medical statements, a possible prescription of Sodium Pentobarbital is not necessarily contra-indicated and thus no longer generally a violation of medical duty of care . . . However, utmost restraint needs to be exercised: it has to be distinguished between the wish to die that is expression of a curable psychic distortion and which calls for treatment, and the wish to die that bases on a self-determined, carefully considered and lasting decision of a lucid person (‘balance suicide’) which possibly needs to be respected. If the wish to die bases on an autonomous, the general situation comprising decision, under certain circumstances even mentally ill may be prescribed Sodium Pentobarbital and thus be granted help to commit suicide.”

⁸ BGE 133 I 58, page 67, consideration 6.1. To be found on-line:

http://relevancy.bger.ch/php/clir/http/index.php?lang=de&type=show_document&page=1&from_date=&to_date=&from_year=1954&to_year=2014&sort=relevance&insertion_date=&from_date_push=&top_subcollection_clir=bge&query_words=&part=all&de_fr=&de_it=&fr_de=&fr_it=&it_de=&it_fr=&orig=&translation=&rank=0&highlight_docid=atf%3A%2F%2F133-I-58%3Ade&number_of_ranks=0&azaclir=clir#page240

And furthermore:

“Whether the prerequisites for this are given, cannot be judged on separated from medical – especially psychiatric – special knowledge and proves to be difficult in practice; therefore, the appropriate assessment requires the presentation of a special in-depth psychiatric opinion...”

Based on this decision, the applicant made efforts to obtain an appropriate assessment, writing to 170 psychiatrists – yet he failed to succeed. Seeing that the Swiss Federal Supreme Court had obviously set up a condition which in practice could not be fulfilled, he took the issue to the European Court of Human Rights.

On January 20th, 2011, the European Court of Human Rights rendered a judgement⁹ and stated in paragraph 51:

”In the light of this jurisdiction, the Court finds that the right of an individual to decide how and when to end his life, provided that said individual was in a position to make up his own mind in that respect and to take the appropriate action, was one aspect of the right to respect for private life under Article 8 of the Convention”

Even though the European Court of Human Rights thus confirmed the statement of the Swiss Federal Supreme Court and also recognized that someone’s decision to determine the way his or her life will end is part of the right to self-determination protected by article 8 § 1 of the Convention, it then failed to postulate a positive obligation for the contracting states of the Convention to give those individuals, who would like to make use of this right, an entitlement against the state to make access possible to the necessary means for safely making use of such right.

In the case of ULRICH KOCH against Germany, the applicant’s wife, suffering from total quadriplegia after falling in front of her doorstep, demanded that she should have been granted authorisation to obtain 15 grams of pentobarbital of sodium, a lethal dose of medication that would have enabled her to end her ordeal by committing suicide at her home. In its decision of July 19th, 2012, the European Court of Human Rights declared the applicant’s complaint about a violation of his wife’s Convention rights inadmissible, however, the Court held that there had been a violation of Article 8 of the Convention in that the [German] domestic courts had refused to examine the merits of the applicant’s motion¹⁰. The case is now pending at the Administration Court of Cologne, and depending on their decision, the case might well continue on to the German Federal Constitutional Court and then again to the European Court of Human Rights.

⁹ Application no. 31322/07; Judgment of a Chamber of the First Section (in French), available online: <http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-102939>

¹⁰ Application no. 479/09, Judgment of the Former Fifth Section, available online: <http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-112282>

In a further case, *GROSS v. Switzerland*, the European Court of Human Rights further developed its jurisdiction. The case concerned a Swiss woman born in 1931, who, for many years, had expressed the wish to end her life, as she felt that she was becoming more and more frail and was unwilling to continue suffering the decline of her physical and mental faculties. After a failed suicide attempt followed by inpatient treatment for six months in a psychiatric hospital which did not alter her wish to die, she tried to obtain a prescription for sodium pentobarbital by Swiss medical practitioners. However, they all rejected her wish, one felt prevented by the code of professional medical conduct being that the woman was not suffering from any illness, another was afraid of being drawn into lengthy judicial proceedings. Attempts by the applicant to obtain the medication to end her life from the Health Board were also to no avail.

In its judgment¹¹ of May 14th, 2013, the European Court of Human Rights held in paragraph 66:

“The Court considers that the uncertainty as to the outcome of her request in a situation concerning a particularly important aspect of her life must have caused the applicant a considerable degree of anguish. The Court concludes that the applicant must have found herself in a state of anguish and uncertainty regarding the extent of her right to end her life which would not have occurred if there had been clear, State-approved guidelines defining the circumstances under which medical practitioners are authorised to issue the requested prescription in cases where an individual has come to a serious decision, in the exercise of his or her free will, to end his or her life, but where death is not imminent as a result of a specific medical condition. The Court acknowledges that there may be difficulties in finding the necessary political consensus on such controversial questions with a profound ethical and moral impact. However, these difficulties are inherent in any democratic process and cannot absolve the authorities from fulfilling their task therein.”

In conclusion, the Court held that Swiss law, while providing the possibility of obtaining a lethal dose of sodium pentobarbital on medical prescription, did not provide sufficient guidelines ensuring clarity as to the extent of this right and that there had been a violation of Article 8 of the Convention. The case was referred to and is now pending at the Grand Chamber of the Court.

In light of these judgments and because of respect for human personal autonomy, which the Court acknowledges as an important principle in order to interpret the guarantees of the Convention, further legal developments are to be expected.

We would like to emphasize that in this context, since the case of *ARTICO v. Italy* (judgment of May 13th, 1980, series A no. 37, no. 6694/74¹²), the developed

¹¹ Application no. 67810/10; Judgment of a Chamber of the Second Section, available online: <http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-119703>

practice (so-called ARTICO-jurisdiction) is of major importance. In paragraph 33 of said judgment the Court explained:

“The Court recalls that the Convention is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective; . . .”

Dignity and freedom of humans mainly consists of acknowledging the right of someone with full capacity of discernment to decide even on existential questions for him- or herself, without outside interference. Everything else would be paternalism compromising said dignity and freedom. In the judgment *DIANE PRETTY v. the United Kingdom*, the Court correctly recognized that this issue will present itself increasingly within the Convention’s jurisdiction, due to demographic developments and progress of medical science.

As the Convention, in the frame of the guarantee of article 8 § 1, comprises the right or the freedom to suicide, then everyone who wishes to make use of this right or freedom has a claim that he or she shall be enabled to do this in a dignified and humane way. Such individuals should not be left to rely on methods which are painful, which comprise a considerable risk of failure and/or endanger third parties. The available method has to enable the individual to pass away in a risk-free, painless manner and within a relatively short time. Such a method must also consider aesthetic aspects in order to enable relatives and friends to attend the process without being traumatized.

3) The protection of life and the general problem of suicide

In the judgment *DIANE PRETTY v. the United Kingdom* mentioned earlier, the European Court of Human Rights rightly paid great attention to the question of the influence of article 2 of the ECHR – the right to life, especially the aspects of protection for the weak and vulnerable. In the meantime, the 14 years of experience of the US-American state of Oregon derived from its “Death With Dignity Act” shows that the question of the weak and vulnerable does not pose a problem in reality: neither the weak nor the vulnerable nor those with insufficient (or even without) health insurance would choose the option of physician assisted suicide, but in fact the self-confident, the above-average educated, the strong ones.¹³

Yet, the principle of protection of life cannot be seen only in the light of the individual life of a single person who wishes a self-determined end to his or her life; it must also be applied in questions regarding public health.

¹² To be found online: <http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-57424>

¹³ See the death with dignity act annual reports of the Department of Human Services of the state of Oregon, to be found online: <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>

Until now, national and international debates on assisted suicide and/or euthanasia never realized that, apart from the small number of individuals who wish to end their life due to severe suffering with one of the few available methods (palliative care, assisted suicide, etc.), there is a problem on a much larger scale which questions the sanctity of life: the general problem of suicide and suicide attempts.

In the year 2012 there were, in Scotland, 830 registered suicides (deaths which are the result of intentional self-harm or events of undetermined intent)¹⁴; the total for the U.K. was 5,981¹⁵.

On average, two individuals die every day in Scotland as a result of a suicide attempt. In England, it is one person every two hours, with men aged 35 to 49 being the group with the highest suicide rate¹⁶. Many other states, like Switzerland, show a very high number of suicides and even higher counts of failed suicide attempts. In response to the request regarding information on suicide and suicide attempts in Switzerland from Andreas Gross, a member of the Swiss National Council, the Swiss government rendered its comments to the parliament on January 9th 2002¹⁷: it explained that, based on scientific research (National Institute of Mental Health in Washington), Switzerland might have up to 67,000 suicide attempts annually – that is 50 times the annual number of 1,350 of fulfilled (and registered) suicides. Thus, the risk of failure of an individual suicide attempt is up to 49:1!

Given the results of the scientific research mentioned before, suicide attempts in Scotland must be estimated to be up to 41,500 per year; for the whole U.K. up to 299,050. Even if the ratio of failed suicide attempts to officially registered suicides was ‘only’ 9:1, as some psychiatrist, therapists and coroners assume (according to the afore mentioned comments of the Swiss government), there would still be 8,300 suicide attempts in Scotland and 59,810 in the U.K.

Referring to the previously mentioned ARTICO-jurisdiction: no matter whether the risk is 49:1 or ‘only’ 9:1, it indicates that an individual can only make use of the right to end his or her life self-determinedly by accepting such a high risk of failure and therefore an unbearable (further) deterioration of his or her state of health. This signifies however, that the right to end ones life self-determinedly under the conditions currently found in Scotland, the U.K. and other contracting states of the ECHR is neither practical nor efficient.

The negative and tragic result of ‘clandestine’ suicides is diverse:

¹⁴ Publications by the General Register Office for Scotland, to be found online:

<http://www.gro-scotland.gov.uk/files2/stats/probable-suicides/suicides-2012-t1.pdf>

¹⁵ Statistical Bulletin by the Office for National Statistics, to be found online:

http://www.ons.gov.uk/ons/dcp171778_351100.pdf

¹⁶ Report on Preventing suicide in England, to be found online:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216928/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

¹⁷ Online (in German): http://www.parlament.ch/d/suche/seiten/geschaefte.aspx?gesch_id=20011105

- high risk of severe physical and mental injuries for the person who attempts suicide;
- psychological problems for next-of-kin and friends of a suicidal person after their attempt and their death;
- personal risks and psychological problems for rescue teams, the police, etc., who have to attend to the scene at or after a suicide attempt;
- enormous costs for the public health care system, especially costs arising from caring for the invalid, and costs for a country's economy (for example due to delay of trains) and costs for the public sector (rescue teams, police, coroner, etc.)¹⁸

Despite the enormous number of committed/fulfilled and failed suicide attempts and their negative effects, governmental measures towards an improved suicide and suicide attempt prevention are few. Some programs seem to focus very much on narrowing access to the means of suicide and a lot of money is spent on constructing fences and nets on bridges and along railway lines. However, these measures do not tackle the problem at its root. By all means, it must be the aim of all efforts to reduce the number of suicides, especially the number of unaccompanied 'clandestine' suicides, and, of course, the much higher number of suicide attempts. For this, the starting point of effective suicide attempt prevention is looking at the root of the problem: the taboo surrounding the issue, the wall of fear of embarrassment, rejection and losing one's independence.

Authorities' restrictions and prohibitions in connection with assisted dying also raise the question of violation of article 3 of the European Convention of Human Rights, the prohibition of torture which states that no one shall be subjected to torture or to inhuman or degrading treatment or punishment. Article 3 could be violated for example if a palliative treatment is made with insufficient effect, thus on the one hand constituting a prohibition of passive euthanasia and on the other hand a forced medication; if physical and emotional suffering and pain of a certain minimum level are given, such approach could possibly fulfill the notion of an inhumane treatment. In the judgment *DIANE PRETTY v. the United Kingdom* mentioned before, the Court avoided to look into the aspect of the states' positive duty to protect individuals from such inhumane treatment in cases of assisted dying. There is room to look into this aspect more closely in future cases¹⁹.

¹⁸ See the study of PETER HOLENSTEIN: <http://www.dignitas.ch/images/stories/pdf/studie-ph-der-preis-der-verzweiflung.pdf>. In Switzerland, in the year 1999, there were 1'269 registered suicides leading to estimated costs of 65,2 Million Swiss Francs; given that the estimated number of suicide attempts is considerably higher (based on information provided by forensic psychiatrists, coroners, etc., the study calculates with a suicide attempt rate that is 10 to 50 times higher than the registered suicides), these costs could well be around 2'431,2 Million Swiss Francs.

¹⁹ See: STEPHAN BREITENMOSER, The right to assisted dying in the light of the ECHR (Das Recht auf Sterbehilfe im Lichte der EMRK), in: Frank Th. Petermann, Assisted Dying – Basic and practical questions (Sterbehilfe – Grundsätzliche und praktische Fragen), p. 184 ff, St. Gallen, 2006.

4) Suicide prevention – experience of DIGNITAS

Everyone should be able to discuss the issue of suicide openly with their General Practitioner, psychiatrist, carers, etc. The taboo which surrounds the topic must be lifted. The possibility of – anonymously as well as openly – using a help-line is a very important service provided by some institutions²⁰. However, for many people ‘talking about it’ does not suffice: they seek the concrete option of a painless, risk-free, dignified and self-determined death, to put an end to their suffering.

DIGNITAS’ experience with all people – no matter whether they suffer from a severe physical ailment or other impairment, or wish to end their life due to a personal crisis – shows that giving them the possibility to talk to someone, for example at our organisation, openly and without fear of being put in a psychiatric clinic, has a very positive effect: they are – and feel that they are – being taken seriously (often for the first time in their life!); through this, they are offered the possibility of discussing solutions to the problem(s) which led them to feeling suicidal in the first place. They are not left to themselves and rejected like many suicidal individuals who cannot discuss their suicidal ideas with others through fear of being ostracized or deprived of freedom in a mental institution for some time.

Furthermore, through their contact with DIGNITAS, not only are their suicidal ideas taken seriously but they also know that they are talking to an institution which could in fact, under certain conditions, arrange for a ‘real way out’. This aspect of authenticity cannot be underestimated.

This ‘talking openly’ unlocks the door to looking at all thinkable options. These include convincing the individuals in a personal crisis to visit a crisis intervention centre, referring severely suffering terminally ill to a hospice or the palliative ward of a appropriately equipped clinic, suggesting alternative treatments, directing patients who feel ill treated by their General Practitioner to other physicians, and so on; always depending on the individual’s needs. Over one third of DIGNITAS’ daily ‘telephone-work’ is counselling individuals who are not even members of the association who thus receive an ‘open ear’ and initial advice free of charge.

The experience of our organisation, drawn from over 16 years of working in the field of suicide prophylaxis and suicide attempt prevention, shows that – paradoxically – the option of an assisted suicide without having to face the severe risks inherent in commonly-known suicide attempts is one of the best methods of preventing suicide attempts and suicide. It may sound paradoxical: in order to prevent suicide attempts, one needs to say ‘yes’ to suicide. Only if suicide as a fact is acknowledged, accepting it generally to be a means given all humans to

²⁰ In Scotland provided for example by The Samaritans, see http://www.samaritans.org/talk_to_someone/find_my_local_branch/scotland.aspx

withdraw from life and also accepting and respecting the individual's request for an end in life, the door can be opened to 'talk about it' and tackle the root of the problem which made the individual suicidal in the first place.

Knowing about a 'real' option will deter many from attempting/committing suicide through insufficient, undignified means. Furthermore, in the preparation of an accompanied suicide, next-of-kin and friends are involved in the preparation process and encouraged to be present during the last hours: this gives them a chance to mentally prepare for the departure of a loved one and thus give their support and affection to the suicidal person until the very end of life.

At this point, we need to take a look at the two main arguments of opponents to legislation of any form of assisted dying: they argue that any form of legalisation could pressure 'vulnerable' individuals to end their life, for example because they would be pushed by loved ones not to be a burden on them anymore. And it is suggested that legalisation would create a 'slippery slope', an unstoppable increase in numbers. The general understanding may be that individuals under the age of 18 or 16, people who are dependent on medical care and those who suffer from a loss of capacity to consent (for example due to dementia) would be classified as vulnerable. However, it is now acknowledged – especially in the very instructive annual reports of the Ministry of Health of the US-American State of Oregon²¹ – that assisted suicide has absolutely nothing to do with 'vulnerable' individuals. Furthermore, 'vulnerable' is a pretext argument which distracts from the real problem: those who become suicidal yet are left alone with their problems, because there is still a taboo surrounding this issue, because the individual's fear of being put in a psychiatric clinic or fear of having his or her suicidal thoughts denounced, belittled, ignored or dismissed. These individuals are the really vulnerable ones. The Journal of Medical Ethics carried an article with the title "Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in vulnerable groups"²². The problem-related relevant part of the abstract of this article has the following wording:

“Background: Debates over legalisation of physician-assisted suicide (PAS) or euthanasia often warn of a 'slippery slope', predicting abuse of people in vulnerable groups. To assess this concern, the authors examined data from Oregon and the Netherlands, the two principal jurisdictions in which physician-assisted dying is legal and data have been collected over a substantial period.

Methods: The data from Oregon (where PAS, now called death under the Oregon 'Death with Dignity Act', is legal) comprised all annual and cumu-

²¹ Death with Dignity Act annual reports of the Department of Human Services of the state of Oregon, to be found online: <http://public.health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx>

²² Journal of Medical Ethics 2007;33:591-597; doi:10.1136/jme.2007.022335, to be found online: <http://jme.bmj.com/content/33/10/591.abstract>

lative Department of Human Services reports 1998–2006 and three independent studies; the data from the Netherlands (where both PAS and euthanasia are now legal) comprised all four government-commissioned nationwide studies of end-of-life decision making (1990, 1995, 2001 and 2005) and specialised studies. Evidence of any disproportionate impact on 10 groups of potentially vulnerable patients was sought.

Results: Rates of assisted dying in Oregon and in the Netherlands showed no evidence of heightened risk for the elderly, women, the uninsured (inapplicable in the Netherlands, where all are insured), people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations. The only group with a heightened risk was people with AIDS. While extralegal cases were not the focus of this study, none have been uncovered in Oregon; among extralegal cases in the Netherlands, there was no evidence of higher rates in vulnerable groups.

Conclusions: Where assisted dying is already legal, there is no current evidence for the claim that legalised PAS or euthanasia will have disproportionate impact on patients in vulnerable groups. Those who received physician-assisted dying in the jurisdictions studied appeared to enjoy comparative social, economic, educational, professional and other privileges.”

Besides, not every individual who may be seen by third parties as vulnerable would personally share this view. One needs to bear in mind: There is a fine line where protection turns into undesired paternalism.

As to the ‘slippery-slope’ argument, we adhere to a statement of the full professor (‘Ordinarius’) for law ethics at the University of Hamburg, Germany, Dr. iur. REINHARD MERKEL, who looked into this argument in his report “Das Dammbrech-Argument in der Sterbehilfe-Debatte” (“The slippery-slope argument in the euthanasia debate”)²³: In this report he emphasized that arguments of this nature have always been the most misused instruments of persuasion in public debates on controversial subjects. They have always been the probate residuum of ideologists and demagogues.

Furthermore, based on the experience of the Zürich City Council, we now know that allowing assisted suicide even in nursing homes for the elderly does not lead to any rise of such assisted/accompanied suicides: of the 16,000 residents in Zürich homes for the elderly, only zero to three assisted suicides per year have

²³ in: FRANK TH. PETERMANN, (ed.), *Sicherheitsfragen der Sterbehilfe* (Safety questions in assisted dying), St. Gallen 2008, p. 125-146

taken place since the authorities allowed associations like EXIT, DIGNITAS and others to access such homes in 2002²⁴.

The issue is not whether someone would make use of assisted suicide: in fact, the majority of members of DIGNITAS who have requested the preparation of an accompanied suicide and who have been granted the ‘provisional green light’ do not make use of the option after all. Based on a study on our work, research into 387 files of members of DIGNITAS, who – through the given procedure in our organisation – received a basic approval from a Swiss physician, a ‘provisional green light’²⁵ as we call it, that he or she would issue the necessary prescription for an assisted suicide, 70 % did not contact us again after such notification. Only 14 % made use of the option of an assisted suicide, some after quite a long time²⁶. For many, the prospect of such a prescription signifies a return to personal choice at a time when their fate is very much governed by their suffering. It enables many to calmly wait for the future development of their illness and not to prematurely make use of an accompanied suicide, let alone take to a ‘clandestine’ suicide attempt with all its risks and dire consequences.

This shows that a liberal solution, which entirely respects the individual who wishes to end his or her suffering, offers more sophisticated results than action which in such situations deprive individuals of their dignity, personal freedom and responsibility for themselves.

5) General remarks on the proposed Assisted Suicide (Scotland) Bill

No one should be forced to leave his or her home in order to make use of the basic human right of deciding on the time and manner of the end of his or her life. The current legal status of assisted dying in Scotland, in the U.K. and in many other countries is not only “inadequate and incoherent” as The Commission on Assisted Dying puts it on the front side of its final report²⁷, the situation is in fact a disgrace for a country which would be considered a part of modern Europe. It forces citizens to travel abroad in order to have freedom of choice. In this context it should be pointed out that only individuals with at least a minimum of financial resources – something that certainly not everyone in Scotland and the U.K. has – can afford to travel to Switzerland in order to make use of the option of a self-determined end in life, which is a further unacceptable discrimination.

²⁴ See the interview with Dr. Albert Wettstein, former Chief of the Zürich City Health Service (available in German) online: <http://www.derbund.ch/schweiz/standard/Natuerlicher-als-mit-Schlaeuchen-im-Koerper-auf-den-Tod-zu-warten/story/13685292?track>

²⁵ For an explanation, read the general info-brochure of DIGNITAS, page 6 - 7, available online: <http://www.dignitas.ch/images/stories/pdf/informations-broschuere-dignitas-e.pdf>

²⁶ Extract of the study (available in German) online: <http://www.dignitas.ch/images/stories/pdf/studie-mr-weisse-dossier-prozentsatz-ftb.pdf>

²⁷ See online: <http://www.demos.co.uk/publications/thecommissiononassisteddying>

Clearly, the public is in favour of freedom of choice in these ‘last issues’²⁸. This public attitude was made very clear in votes in the Canton of Zürich, Switzerland, on 15 May 2011: two fundamental-religious political groups brought two initiatives to the people’s vote, of which one initiative aimed to prohibit the current legal possibility of assisted suicide entirely whilst the other aimed to prohibit access for non-Swiss citizens and non-residents of the Canton of Zürich. The result was overwhelming: even though a large part of the media had tried for years to scandalise the work of DIGNITAS through inaccurate, dumb tabloid-style press coverage, the public voted by a huge majority of 85:15 and 78:22 against any narrowing of the current legal status quo²⁹.

If Scotland (and other countries too) implements a law which allows a competent individual to have a safe, dignified, self-determined accompanied end in life in their own home, the very goal of the DIGNITAS-organisation is closer in reach: to become obsolete. Because, if people in Scotland have a real choice, no Scottish citizen needs to travel to Switzerland and become a ‘freedom-tourist’ (which is a term certainly more precise and appropriate than ‘suicide-tourist’) and thus DIGNITAS is not necessary anymore for them.

In the light of this, as mentioned before, DIGNITAS very much welcomes the proposal for a Bill providing a means for certain people who are approaching the end of their lives to seek assistance to end their lives at a time of their own choosing, and to provide protection in law for those providing that assistance.

Based on experience drawn from over 16 years of operating, DIGNITAS very much adheres to the late Margo MacDonald’s statement in her first proposal for such a Bill that “advances in palliative care and medical practice mean that most people are likely to experience the peaceful and dignified end to their life that we all seek”, yet that “unfortunately this is not true in every case...“. Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual³⁰. Palliative care is widely accepted and practiced. It is the means of choice if the suffering of the individual is intolerable (in the personal view of the patient, of course) and the life expectancy is only a matter of a few days. It is certainly humanitarian and good practice in the sense of ‘the Good Samaritan’ to

²⁸ See for example the First Report of the Select Committee on Assisted Dying for the Terminally Ill Bill, to be found online: <http://www.parliament.the-stationery-office.co.uk/pa/ld200405/ldselect/ldasdy/86/8609.htm> or the BBVA Foundation Study European Mindset, the ISOPUBLIC/GALLUP Poll http://www.medizinalrecht.org/wp-content/uploads/2013/03/Results_opinion_poll_self-determination_at_the_end_of_life.pdf and others more.

²⁹ For links to the official statistics and a choice of media coverage on the results of the votes see online: http://www.dignitas.ch/index.php?option=com_content&view=article&id=26&Itemid=6&lang=en (on the site, scroll down to the comment/entry of 16 May 2011).

³⁰ Definition by the World Health Organisation, see online: <http://www.who.int/cancer/palliative/definition/en>

give a suffering, dying patient all the end of life care necessary and requested by the patient in order to soothe his or her ordeal.

Palliative care and assisted suicide are not two practices in conflict but in fact they have a complementary relationship even though sometimes the opposite is claimed, usually by opponents of assisted dying options. Almost every day DIGNITAS receives calls for help from patients stricken by the final stage of terminal cancer as well as their relatives and friends. As the administrative proceedings involved with the preparation of an assisted/accompanied suicide take quite some time, usually several weeks if not months, terminally ill patients are always recommended to pursue palliative treatment possibly leading to continuous deep sedation (sometimes also called terminal sedation). Thus, DIGNITAS has directed uncountable patients towards palliative care, has given advice how to access the support of specialist doctors, how to implement patient's advance directives / patient's living wills in a way that it would give safety to the patient and also to the doctors practising palliative care, etc.

Voices claiming that palliative care “can solve anything” and “soothes any suffering” are not in touch with reality and try to mislead the public. There are sufferings for which medical science has still no cure, yet, for which palliative treatment is not an option or possibly only useful in a very advanced late stage of that illness, given that these illnesses are not terminal as such, at least not in the short run. Patients suffering from neurological illnesses such as Amyotrophic Lateral Sclerosis (Motor Neurone Disease), Multiple Sclerosis, etc., or even more so quadriplegics³¹ or patients suffering from a multitude of ailments related to old age³² are generally not *per se* eligible for palliative care and terminal sedation because they are not suffering from a life-threatening illness as such. Long-time degenerative neurological disease are, alongside terminal cancer, the ‘typical diagnosis’ why patient would seek (and in Switzerland usually obtain) the option of an assisted suicide. Certainly, these patients receive medical treatment for pain relief, but that cannot be compared with the dosages applied in end-of-life palliative care. Without doubt, such patients are experiencing severe suffering which can lead them to wish to end their suffering and life. In such cases, the wish for an accompanied (assisted) suicide is a personal choice which must be respected.

Still, we need to be clear about the fact that only a tiny minority of individuals would actually make use of an assisted suicide. First of all, for many, medical science offers relief, and second, for some – as the late Margo MacDonald quite rightly put it – “the legal right to seek assistance to end life before nature decrees is irrelevant due to their faith or credo”; yet there is a third important reason why in fact only a minority of patients would ‘go all the way’ and make use

³¹ Such as for example the rugby-player Daniel James who was left paralysed with no function of his limbs, pain in his fingers, spasms, incontinence and needing 24 hour care after a sports accident.

³² Such as for example the well-known British conductor Sir Edward Downes

of an assisted suicide: it's the fact that 'having the option gives peace of mind'. Having no hope, no prospect, not even the slightest chance of something to cling on is what we humans dislike most. We would like to have at least a feeling of being in control of things. Faced with a severe illness, patients usually ask their doctor: "will I get better?" or: "how much more time do I have?" but an exact medical prognosis is generally difficult if not impossible as the course of disease is different with each individual. In this situation, having options, including the option of a self-determined ending of suffering and life in the sense of an 'emergency exit', can lift the feeling of 'losing control'; this is what members of DIGNITAS tell us again and again. Legalising assisted suicide is not about "doing it" but about "having the option of doing it".

At this point, it is important to stress that all this is about assisted/accompanied suicide – not about euthanasia. It is about the personal decision of a competent individual assuming responsibility for his or her own life and also about this individual being able to self-administer the lethal drug – not about a third person making decisions on behalf of this individual and taking actions to induce death. It is always the patient who is in charge, who decides which steps will be taken – until the very last moment. "Euthanasia" is a term rooted in the Greek language, meaning "good, mild, gentle death". However, its use and meaning ranges from all sorts of help at the end of life, to putting down animals, and to atrocities of the holocaust during WWII. Active euthanasia must be considered as murder or manslaughter and is a crime in Switzerland just as much as it is a crime in Scotland.

In this context one needs to remember that much of the U.K. media – especially the tabloids – are notorious for spreading nonsense such as there being the option of "euthanasia" at a "Dignitas-clinic" where people would take "poison" or a "lethal cocktail", etc.; thus not only showing their incompetence but also their irresponsibility towards their actual task of informing the public in an accurate, balanced way. Questions of life and death have always been subject to sensationalism. Deliberately or unintentionally generating life just as well as deliberately ending life can be well considered as the primary sensation to which the media has related to for centuries. Today's media – and even many politicians – mainly draw their existence from offering their consumers a daily motive for emotional outrage. The Zürich full professor in sociology, KURT IMHOF, made this clear in an interview that he granted the "Neue Zürcher Zeitung" (NZZ) on December 8th, 2007, stating that the result of such media coverage lies much further within the field of fiction than fact³³.

DIGNITAS favours the option of assisted (accompanied) suicide such as Swiss law allows them to practice and which the Swiss associations have been offering

³³ Article to be found online (in German): <http://www.nzz.ch/aktuell/startseite/medienpopulismus-schadet-der-aufklaerung-1.595885>

to their members for over 30 years now. Assisted (accompanied) suicide implies the following:

- The individual is respected in his or her request to have an end to his or her suffering.
- This request is explicitly expressed by the individual, not only once but several times during the process of preparation and re-confirmed even in the final minute prior to the assistance. (In the case of accompanied suicide in Switzerland, this is the moment prior to handing over the lethal drug to the individual).
- The individual expresses his or her desire to end his or her life not only verbally but undertakes the last act in his or her life him- or herself. (In the case of accompanied suicide in Switzerland, this is the action of the individual actually drinking the lethal drug or absorbing it in another form such as feeding it him- or herself through a PEG-tube or intravenous).
- All actions are based exclusively on the explicit will of the individual.
- With assisted/accompanied suicide, the individual always has to do the last act himself or herself; without such final act of the individual, there will be no ending of life. Thus, the taboo of ending someone's life actively (on request by the patient, which would be voluntary euthanasia or even without such request which would be non-voluntary, active euthanasia) does not have to be broken.
- Access to the option of an assisted suicide has a very important, yet all too often overlooked suicide attempt preventative effect, as already outlined earlier in this submission.

However, these aspects of assisted/accompanied suicide cannot hide the fact that with assisted suicide 'only', some individuals would be excluded from assistance in dying: an individual in a coma or suffering from advanced dementia would not be able to express his or her will, would not have sufficient capacity to consent and/or simply would not be able to do the last act which brings about the end of suffering and life him- or herself. For these situations, a different approach will be necessary and is already in place to some extent at least: the strengthening and implementation of the already wide-spread and widely accepted Patient's Advance Decisions (also called Patient's Advance Directives or Patient's Living Will) and possibly even regulations on how to implement (voluntary and non-voluntary) euthanasia such as in The Netherlands, Belgium and Luxembourg. Still, based on DIGNITAS' experience, the large majority of requests for an individual's dignified end in life can be covered by assisted (accompanied) suicide.

The proposed Assisted Suicide (Scotland) Bill is based on the models in place in the US-State of Oregon and in Switzerland. Both jurisdictions clearly do not allow for euthanasia but for assisted suicide. Both jurisdictions insist that only competent individuals who are able to self-administer the means to end his or

her life would fall within the framework of the model. Indeed, this is about allowing people who actively wish to retain control of their lives to secure a dignified death at a time of their own choosing, instead of having to endure a poor and declining quality of life until such time as they die as a result of their illness or condition.

7) Comments on the 11 specific questions raised by the Committee on the proposed Assisted Suicide (Scotland) Bill.

Q1. Do you agree with the general purpose of the Bill to make it permissible, in the circumstances provided for, to assist another to commit suicide?

Yes. According to the policy memorandum³⁴, the Bill has the purpose of providing a means for certain people to seek assistance to end their lives at a time of their own choosing, and to provide protection in law for those providing that assistance. In this, we have identified four aims of the Bill, which are:

- 1) It will give any person who meets the eligibility requirements the right to request medication to end their own life;
- 2) It will set out a three stage declaration and request process for a person to follow;
- 3) It will require a trained and “licensed facilitator” to be present and assist when a person takes their own life
- 4) It will provide protection in law of those who assist a person to end their own life within the parameters set by the Bill;

Regarding aim 1):

DIGNITAS defends the right of an individual to have access to a self-determined, dignified and risk-free end in life in the case that individual chooses this option and therefore fully supports this aim.

Regarding aim 2):

This aim matches the “Swiss model”; DIGNITAS supports the three stage declaration as we have seen from many years of experience that such approach satisfies the requirements of professionally assessing the individual request and documenting it.

Regarding aims 3) and 4):

As pointed out earlier in this submission, there is a massive social tragedy of ‘clandestine’ suicides and even more so failed suicide attempts with all their dire consequences. This is clearly due to the fact that those who wish to end their life are left to use inadequate means and have to act all alone, without prior professional advice. Aim 4 is directly derived from the Swiss model which is not ‘on-

³⁴ http://www.scottish.parliament.uk/S4_Bills/Assisted%20Suicide/b40s4-introd-pm.pdf

ly' about "assisted" but in fact about "accompanied" suicide. With DIGNITAS, there are always two professionals present during the entire process, from welcoming the individual and his or her loved ones, sorting out the paperwork (such as the 'voluntary death declaration', the 'disposition of personal belongings', etc.), assessing the competence, self-determination and decidedness of the individual once again, preparing the lethal drug (the Swiss model ensures a chain of custody in which the individual would not get hold of the lethal drug until the very last minute if they decide to make use of it), taking care of the loved ones present in the last hour, and dealing with the proceedings after the demise of the individual (calling the police and the coroner and helping them with all issues relating to the authorities' investigation, calling the funeral parlour, etc.). This professional attendance to all needs of the individual, to his or her close ones, and also to the requirements of ensuring safety during the process and control mechanisms makes all the difference. The proposed Assisted Suicide (Scotland) Bill adheres to safety and quality requirements and DIGNITAS agrees with them.

Q2. Do you have any views on how the provisions in this Bill compare with those from the previous End of Life Assistance (Scotland) Bill?

The End of Life Assistance (Scotland) Bill (SP Bill 38) as introduced in the Scottish Parliament on January 20th, 2010, included a person who "is permanently physically incapacitated to such an extent as not to be able to live independently and finds life intolerable" (schedule 4, subsection 2 b). However, the Assisted Suicide (Scotland) Bill as introduced on November 14th, 2013 excludes such a person, limiting access to an assisted suicide to those who have an illness that is, for the person, either terminal or life-shortening; or a condition that is, for the person progressive and either terminal or life-shortening. This limitation is discriminating against those people who are severely suffering but do not fall within the category of the new Bill. We shall further look into this aspect in our answer to question 5 (Q5.)

However, there are changes which are clearly an improvement: A person does not need anymore to be registered with a medical practice in Scotland for a continuous period of at least 18 months prior to having the possibility of making a first request for assistance. Furthermore, for the first request, the hardly to fulfill task of the person having to find two witnesses who would sign a statement is a bit eased to having to find one such witness.

Q3. The Bill precludes any criminal and civil liability for those providing assistance, providing the processes and requirements set out in the Bill have been adhered to. Do you wish to make any comment on this?

The sections of Part 1 of the Bill are most important as they clarify that 1) actions taking place within the frame of the requirements of the Bill – and only

such actions – are lawful and protected and 2) anyone qualifying to be involved in the process, such as a practitioner, a facilitator or a proxy, would actually be prepared to be act in the benefit of a suffering person; if the Bill did not offer some protection for those providing assistance, the Bill would quite likely become ‘dead letter’ because nobody would want to run a risk.

Q4. The Bill outlines a three stage declaration and request process that would be required to be followed by an individual seeking assisted suicide. Do you have any comment on the process being proposed?

As we can see, the three stage declaration and request process suggests, in short, that the person must

Stage 1): make a written preliminary declaration – for which the person must be registered as a patient with a medical practice in Scotland, must find a witness being present when he or she signs the declaration and also signing a witness statement, and find a practitioner endorsing the declaration so that it be recorded in the medical records;

Stage 2): make a written first request for assistance – for which he or she must have fulfilled the requirements of stage 1 and waited for at least 7 days, be registered as a patient with a medical practice in Scotland, has an illness that is either terminal or life-shortening or a condition that is progressive and either terminal or life-shortening, must find two different practitioners signing a statement on this request;

Stage 3): make a written second request for assistance – for which he or she must have fulfilled the requirements of stage 1 and 2 and waited for at least 14 days, be registered as a patient with a medical practice in Scotland, has an illness that is either terminal or life-shortening or a condition that is progressive and either terminal or life-shortening, must find two different practitioners signing a statement on this request;

We presume that the prerequisite of having to be registered with a medical practice is derived from the Swiss model as an individual could only obtain the preferable means for an accompanied suicide – Pentobarbital of Sodium – through a medical doctor (licensed to practice medicine). However, we do not see a reason why an individual should mandatorily be registered with a medical practice. As far as we can see, the preliminary declaration may well take place at a time when an individual is still perfectly healthy. Such an individual may not have a relation with a medical practice at all, and those who are healthy would not feel the need to see a doctor. If any preliminary declaration shall be part of the process, the registration of such could be just as well with another instance: for example with the office of the Scottish Directorate of Health & Social Care (as a state body) or – to match the Swiss model – an organisation similar to DIGNITAS, such as FATE – Friends At The End in Glasgow (as a private body).

Such state or private body could, besides registering the preliminary declaration, take on the task of a witness at the same time.

At this point, we need to look in general at the issue of having some sort of ‘gatekeeper’ giving consent (or not) for an assisted/accompanied suicide:

Up front, there can be only one person making the final decision on whether to continue with life or put an end to it: the individual him- or herself. As stated before, DIGNITAS favours the possibility of assisted (accompanied) suicide which implies that a) the individual has the capacity to consent and thus rationally express his or her will to end his or her life and b) the individual is able to carry out the final act which puts an end to his or her life (for example drinking the lethal barbiturate) by him- or herself.

Basically, any intervention by third parties with requests by individuals who wish to end their life stands in conflict with the individual’s right to self-determination and thus implies paternalism. However, we must not ignore the fact that some form of ‘gate keeping’ would make sense: the request of a patient stricken with terminal cancer must not be lumped together with the request of a young man suffering after the breakdown of the relationship with his girlfriend. Whilst both requests are to be taken seriously and should be respected up-front – this being the base of an authentic suicide-attempt prevention approach – the patient suffering from cancer certainly needs a different kind of attention to his or her request than the young man. In the first case, counselling on alternative options such as palliative care and the preparation of at least an option to an assisted suicide (what we at DIGNITAS call the ‘provisional green light’) are the means of choice, whilst in the latter case counselling making it clear that “other parents have beautiful daughters too” should take place. However, as already stated, in both cases the principle of respecting person’s request to end their life and certainly not denouncing, belittling, ignoring or dismissing that request should be the rule. Individuals who express a wish to end their suffering have valid personal reasons to do so – they want to be acknowledged and heard and not simply be dismissed as “being in a crisis” or even committed to a psychiatric clinic.

In this context, one should not overlook the fact that several completely different types of suicidal individuals may be found who are rarely comparable one to another. Quite a number of commonly heard phrases – like “a suicide attempt is normally just a cry for help”, “80 % of people who have survived a suicide attempt would not like to repeat it”, “someone who talks about suicide will not do it” – are simply “thought savers” (an expression created by the American journalist LINCOLN STEFFENS, a friend of President Theodore Roosevelt³⁵). “Thought savers” are a way to stop thinking about a particular problem without solving it. It is quite significant that such “thought savers” are very common in

³⁵ In: The Autobiography of Lincoln Steffens

relation to the suicide problem. With a “thought saver”, one may get rid of the problem, belittling it so that it appears no longer worth thinking about. Hardly anyone asks, for instance when speaking of a “cry for help”: why does this person feel the need to undertake the risk of a suicide attempt in order to find help, instead of talking to other people and saying that they need help? In the special case of a suicidal situation, the reason for the “cry for help” without words is the risk of losing one’s liberty (due to being put in a psychiatric clinic) or the risk of not being taken seriously or being rejected (deprived of affection) if one talks to someone else about suicidal ideas. At DIGNITAS, we hear again and again how individuals felt a major relief after having had the opportunity of speaking to us openly about their idea to attempt suicide: these individuals acknowledge that being taken seriously and receiving honest information on the possibilities at the end of life and the risks involved with a self-attempted suicide helped them to ease the urgency of the feeling of wanting to die as soon as possible.

In Switzerland, the ‘gate keepers’ are basically medical doctors. Only a medical doctor can prescribe the lethal drug Pentobarbital of Sodium which is the one drug of choice for a dignified, risk-free and painless accompanied suicide. Furthermore, associations like EXIT and DIGNITAS are the ones with many years of experience and trained staff to take care of the requests by individuals wishing to end their life and arrange for accompanied suicides in the framework of the Swiss law. However, many medical doctors understandably argue that they should not be burdened with the responsibility of being the one and only gatekeepers of access to a self-determined end in life.

Now let us turn to the Assisted Suicide (Scotland) Bill:

The proposed system of a first and then a second request basically adheres to the “Swiss model”: with DIGNITAS, if a person wishes to start the procedure towards an assisted/accompanied suicide in Switzerland, he or she (as well as having had to register beforehand) has to place a formal request³⁶ with DIGNITAS which is then assessed by the organisation as well as at least one (of the organisation independent) Swiss medical doctor. If such medical doctor gives basic consent to the request (which is the ‘provisional green light’) and if the individual then wishes to move to the next stage, which would be at least one mandatory consultation with the medical doctor possibly followed by the actual accompanied suicide, the individual in question will have to make a second request expressing his or her wish to make use of said ‘provisional green light’.

Adhering to the case of HAAS v. Switzerland mentioned before – during which the individual contacted 170 psychiatrists yet did not find a single medical doctor acknowledging his request – as well as the general reluctance of medical doctors towards end-of-life-questions, DIGNITAS feels that having to find two

³⁶ For details see page 6 of the info-brochure of DIGNITAS, available online: <http://www.dignitas.ch/images/stories/pdf/informations-broschuere-dignitas-e.pdf>

different registered medical practitioners, each making a statement, that is, acknowledging the request, would be a prerequisite too strict, a hurdle too high.

If the majority or even all medical doctors in Scotland refuse to assess / acknowledge requests and write statements for personal reasons – which it is their right to do – then getting the requests acknowledged becomes almost or entirely a “mission impossible”, especially in the light of needing two medical practitioners giving consent. Even in Switzerland, which has a model of (at least) one medical doctor assessing the patient’s request for an assisted suicide, this requirement is the “bottleneck” of dealing with requests for assisted suicide as it is very difficult to find cooperating, liberal medical doctors.

Therefore, it should be implemented in the Bill that the one medical practitioner’s statement is sufficient and that he or she is free to choose contacting a colleague in order to obtain a second opinion, but this not having to be a prerequisite.

Regarding the proposed waiting period of 14 days between the first and the second request: such a waiting period should not be implemented, because, for a terminal cancer patient for example suffering from bone metastases which are known to cause extreme pain, 14 days is a very long time. DIGNITAS proposes the “Swiss model” which has a one-formal-request approach, involving one medical doctor, whom the patient can contact and access again as soon as a ‘provisional green light’ for assisted suicide is given. A fixed waiting period is not necessary as automatically, ‘straight-forward’ requests will be acknowledged quicker whilst more complicated ‘cases’ would take more time to assess.

In any case, the time during the formal request(s) should be used to explore and suggest alternatives such as changes in medical routine, counselling, hospice and respite care, etc., without the person having the obligation to consider these alternatives. In fact, not only during a waiting period (no matter how short or long) of the assessment proceedings towards an assisted suicide, but at all times of contact between a patient and his or her practitioner, an in-depth exploring and suggesting of treatments and alternatives should take place. Common sense would lead one to think that this is already implemented in the general practice of health care but, unfortunately, this is not the case. From our long-standing experience we at DIGNITAS see again and again that patients are not being sufficiently informed by their practitioners. A large part of DIGNITAS’ counselling work is telling inquirers about palliative care options, health care advance directives, patient’s rights, and so on. At DIGNITAS, we even have medical doctors and nurses contacting us to inquire how they could help their patients. To some extent, this is hardly surprising: during their studies to become medical doctors, end-of-life issues are hardly mentioned in lectures, if at all; sometimes the subject is discussed during a few hours on ‘medical ethics’. But the issue should be tackled in a ‘matter-of-fact’ approach, not in the frame of ethical theories. Thus,

DIGNITAS strongly suggests intensifying the exploring alternatives aspect beyond any waiting period.

Q5. Do you have any comment on the provisions requiring that the person seeking assisted suicide must have a terminal or life-shortening illness, or a progressive condition which is either terminal or life-shortening?

It is generally and widely accepted that individuals suffering from a physical terminal or life-shortening illness or progressive condition such as most forms of cancer, Amyotrophic Lateral Sclerosis (Motor Neurone Disease), Multiple Sclerosis, Parkinson's, etc. should be eligible for assistance with assisted suicide. The Bill adheres to this. However, questions on defining "terminal", "life-shortening" and "progressive" could come up. Furthermore, there could be 'categories' of suffering individuals who would be eligible for assistance under the "Swiss model" yet who are explicitly excluded by the Assisted Suicide (Scotland) Bill, such as paraplegics and quadriplegics³⁷. In addition, individuals suffering from mental illness also have a right to a self-determined end in life as long as they have capacity to consent: the Swiss Federal Supreme Court, in its decision of November 3rd 2006³⁸ acknowledged this, as mentioned before.

Overall, limiting access to assisted suicide to certain individuals automatically leads to a discrimination against those excluded. What is even worse, those excluded are exposed to the high risks connected with 'clandestine' suicide attempts via inadequate means with all the dire consequences for them, their loved ones and third parties. From a humanitarian perspective, restricting an individual's access to a risk-free, dignified and assisted/accompanied suicide cannot be justified.

Furthermore, from a legal, human rights perspective, setting up categories which would include and exclude certain individuals from having access to a self-determined end in life could constitute an unlawful discrimination. Article 14 of the European Convention on Human Rights (ECHR) states:

"Prohibition of discrimination

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status."

³⁷ Such as for example the rugby-player Daniel James who was left paralysed with no function of his limbs, pain in his fingers, spasms, incontinence and needing 24 hour care after a sports accident.

³⁸ BGE 133 I 58, to be found on-line:

http://relevancy.bger.ch/php/clir/http/index.php?lang=de&type=show_document&page=1&from_date=&to_date=&from_year=1954&to_year=2014&sort=relevance&insertion_date=&from_date_push=&top_subcollecti on_clir=bge&query_words=&part=all&de_fr=&de_it=&fr_de=&fr_it=&it_de=&it_fr=&orig=&translation=&rank=0&highlight_docid=atf%3A%2F%2F133-I-58%3Ade&number_of_ranks=0&azaclir=clir#page240

As mentioned earlier in this submission, the European Court of Human Rights has a well-established standing on the practicability and efficiency of its guaranteed rights and freedoms through its ARTICO-jurisdiction:

“The Court recalls that the Convention is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective;...”³⁹

Given that, as mentioned before, the European Court on Human Rights basically acknowledged the right of an individual to decide how and when to end his or her life, a narrowing of access to this right could constitute a conflict with the Convention.

Generally, the European Court on Human Rights has stated on several occasions that the ECHR has to be read as a whole. The Convention revolves around the idea of ‘man’ as a mature individual, fully responsible for his or her actions. This is the form of the enlightened individual in the sense of the philosopher IMMANUEL KANT, that is as an individual who has freed him- or herself from self-inflicted immaturity and thus from governmental, religious and other social paternalism.

DIGNITAS acknowledges that in legislation one has to “draw a line somewhere” in order to establish a legal frame. However, the notion of ‘terminal’ and ‘life-shortening’ is not appropriate eligibility requirement as it is too narrow and above all discriminating – and thus should be changed.

Q6. Are you satisfied with the eligibility requirements as regards age, capacity, and connection with Scotland as set out in the Bill?

1) Regarding that the person must be aged 16 or over

This eligibility requirement takes legal age as the ‘starting point’ of being able to access the option of an assisted/accompanied suicide. But how about under 16-year-old individuals? Wouldn’t maybe a 15 year old terminal cancer patient have just as much insight into his or her suffering and have the mental capacity to make an informed, rational decision on ending his or her own life self-determinedly? For example, article 19 of the Swiss Civil Code states that “Minors or wards of court with the capacity to consent may assume obligations by their own acts only with the consent of their legal representatives“ yet, „without such consent, they may acquire benefits which are free of charge and exercise strictly personal rights”⁴⁰. Obviously, minors have and may also exercise personal rights. DIGNITAS acknowledges that in legislation one has to “draw a line somewhere” in order to establish a legal frame; thus, the criterion of legal age makes sense, however, one shall not oversee the aspect of discrimination due to age.

³⁹ Case of ARTICO v. Italy (judgment of May 13th, 1980, series A no. 37, no. 6694/74), paragraph 33, to be found online: <http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-57424>

⁴⁰ See online: <http://www.admin.ch/ch/e/rs/2/210.en.pdf>

2) Regarding capacity

Mental capacity to make an informed decision is the basis for individuals not only to express their will but also to ensure that such will is effective in the frame of the given legal system. The Adults with Incapacity (Scotland) Act 2000 states in part 1, section (6) (a) to (e) that, basically, a person is capable if that person is *not* incapable (*e contrario*) of “acting or making decisions or communicating decisions or understanding decision or retaining the memory of decision by reason of mental disorder or of inability to communicate because of physical disability...”⁴¹. This corresponds to the approach of all jurisdictions – as far as we can see – which up front presume any adult to be mentally competent unless they fail to meet certain given criteria which could lead one to assume that their capacity might be limited or even lacking; for example such as is enshrined in Swiss Civil Code article 16 which states: “A person is capable of judgement within the meaning of the law if he or she does not lack the capacity to act rationally by virtue of being under age or because of a mental disability, mental disorder, intoxication or similar circumstances”⁴². Any individual – with at least a minimum of physical autonomy – no matter whether mentally competent or not, can attempt and/or commit suicide; however, it is clear that if it shall be a rational, well-considered decision with involvement of third persons, mental capacity to make an informed decision must be given. This criterion matches the ‘Swiss model’ and it is appropriate.

3) Regarding the connection with Scotland

As it is pointed out in paragraph 55 of the Policy Memorandum, it was one of the policy decisions to require anyone seeking an assisted suicide to be registered with a medical practice in Scotland, because there were concerns that the Bill might lead to a cross-border traffic in people resident elsewhere travelling to Scotland to seek an assisted suicide.

We have commented on the aspect of having to be registered with a medical practice under question 4 already.

As to the consequence of the Bill, in practice, providing access to people living in Scotland only, we see this again as an approach to “draw the line somewhere”. As it is well known, the Swiss legal situation in regard of assisted suicide has a more liberal approach. The background is a humanitarian approach: what is the difference between a person suffering from terminal cancer on the north side of the River Tweed and another person living south of it? Is it not inhumane and a discrimination to give access to a dignified, self-determined ending of suffering to the one person and, at the same time, tell the other person “your passport has the wrong colour”?

⁴¹ See online: <http://www.legislation.gov.uk/asp/2000/4/section/1>

⁴² See online: <http://www.admin.ch/ch/e/rs/2/210.en.pdf>

The term “suicide tourism” is often (mis)used; however, people from abroad coming to DIGNITAS are not suicide tourists. They are, in fact, “freedom tourists” or “self-determination tourists”.

Q7. Do you have any comment on the roles of medical practitioners and pharmacists as provided for in the Bill?

Regarding the roles of medical practitioners we refer to our comment on Question Q4. The Swiss scientist FRANK TH. PETERMANN showed in his publication “Capacity to Consent (Urteilsfähigkeit)”⁴³, the numerous problems which derive from intending to make medical doctors the ‘gate-keepers’ of assisted suicide. Through giving third parties the responsibility for deciding whether somebody who requests an assisted death should be eligible for assistance, paternalism over individuals is enforced instead of strengthening the self-determination of individuals, a result which is in direct contradiction with the meaning and content of the ECHR.

As to the provision of the medication, the proposal of a pharmacist dispensing the lethal drug based on the prescription by the medical doctor and giving it to the ‘facilitator’: this matches the ‘Swiss model’. Granting pharmacists the same right of refusing to dispense the drug for personal reasons just as it would be open to practitioners to decline to get involved, respects their liberty; however, one must not overlook the fact that the above-indicated problem with medical doctors may well also apply to pharmacists, if a majority or even all pharmacist refuse to dispense the drug, thus making the procedure in line with the Assisted Suicide (Scotland) Bill a ‘mission impossible’ for the person wishing to access an assisted/accompanied suicide. Of course, freedom of choice on the side of the individual who wishes to put an end to his or her life also has to respect freedom of choice for individual practitioner and pharmacists to get involved or not in the procedure leading to an assisted suicide. However, this could lead to a conflict between the liberty of a suffering person to choose and access an assisted suicide and the liberty of practitioners and pharmacists to refuse this access due to personal reasons. This conflict should be resolved. A possible solution could be to put an obligation on a state-owned pharmacy to dispense the medication, if all prerequisites set out in the Bill are fulfilled.

Q8. Do you have any comment on the means by which a person would be permitted to end his/her life under the Bill?

Based on the experience of DIGNITAS deriving from over 1,700 accompanied suicides in 16 years, the one drug of choice for a dignified, risk-free and painless

⁴³ FRANK TH. PETERMANN, capacity to consent (Urteilsfähigkeit), pages 81 - 85, ciphers 228 - 234

accompanied suicide is Sodium Pentobarbital⁴⁴, a dosage of 15 - 20 grams. This drug is a fast-acting barbiturate which has been used (in small dosages) for short-term treatment of insomnia and anaesthetic. In small dosage it is not lethal as it is not a poison. However, in large dosage it will lead to unconsciousness and a deep coma within 3 - 5 minutes and, after 20 - 40 minutes it will affect the breathing which will become shallow and finally stop, like a natural dying process. The drug is easy to handle because it is a powder, which at the time of use is dissolved in a small quantity of simple tap water, after which it is ingested orally. If need be, it can also be ingested intravenously or via PEG.

There are a few other drugs (and combinations of drugs) available which would have a similar effect and which could be used as well, however, to DIGNITAS experience, Sodium Pentobarbital is the best choice.

Q9. Do you have any comment on the role of licensed facilitators as provided for in the Bill?

Regarding the role of the licenced facilitators we also refer to our comment on Question 1. The proposed presence of a trained and licensed ‘facilitator’ (at DIGNITAS we speak of ‘befriender’ or ‘companion’), very much matches the “Swiss model”. This is what assisted suicide (with such a facilitator ‘accompanied suicide’ as we call it at DIGNITAS) is all about: someone is there in the last hours with the person who wishes to end his or her life, attending to his or her needs, thus making a sharp distinction with all the lonely ‘clandestine’ suicides and suicide attempts with their dire consequences. DIGNITAS supports the presence of a trained and licenced facilitator as the advantages are manifold:

- 1) there is a chain of custody for the lethal drug, ensuring that this drug reaches only the person and – if not used – is returned to the pharmacy
- 2) it is a safety measure as the trained facilitator would instruct the person on how to take the drug, thus avoiding a failed suicide
- 3) the facilitator could check on the capacity of discernment of the person just like the medical doctors before him or her and look into the stability of the wish to die
- 4) the assisted suicide is witnessed, profoundly facilitating the work of the authorities, especially the police who would otherwise – with a not-yet-determined cause of death – have to start a time-consuming (and costly) investigation
- 5) the facilitator, as outlined in section 19 (b) would offer comfort and reassurance to the person, thus attending to the emotional needs of the person and to the loved ones present in the last hour.

⁴⁴ <http://pubchem.ncbi.nlm.nih.gov/summary/summary.cgi?cid=4737>

As a point of difference to the Bill, at DIGNITAS there are always *two* ‘facilitators’ present. The majority of accompanied suicides at DIGNITAS take place in the presence of relatives and friends of the person: in fact, DIGNITAS very much encourages the person to have his or her loved ones present. In this situation, it is very advantageous to have one facilitator who is able to concentrate on taking care of the person wishing to have the assisted suicide whilst the second facilitator is available to attend to the needs of the family members and friends of the patient. Having two facilitators present is a safety and quality control measure in the sense that “four eyes are better than two”.

Q10. Do you have any comment on the role of the police as provided for in the Bill?

The role of the police, as it is outlined in the Policy Memorandum paragraph 49, basically matches the approach in Switzerland, where each assisted suicide is reported to the police. However, it would be necessary to define more closely what is meant by “It would then be for the police to make any investigation *they consider necessary*” and “Should there be any reason for *believing* that the process set out in the Bill was not properly followed . . .” The police and the procurator fiscal should have a clear legal frame as to how to carry out their investigation. This, order to prevent possible arbitrary acts by these authorities which, for example in the cases of accompanied suicides in Switzerland, are an increasing problem. One may assume that the authorities should work correctly at all times, however, such assumption is naïve. The authorities need to be controlled just as much as the process towards an assisted suicide itself.

Q11. Do you have any comment to make about the Bill not already covered in your answers to the questions above?

DIGNITAS would like to congratulate and thank everyone involved in the making of this Assisted Suicide (Scotland) Bill. This Bill is an important step forward towards the right of individuals to decide on their time and manner of end in life, which has been confirmed by the European Court of Human Rights (see chapter 2 of this submission) being respected and the frame within which such proceedings take place is implemented in domestic law, thus making it clear for everyone. Legal certainty is the base for the functioning of a (democratic) society. DIGNITAS supports this Bill as it aims at respecting and implementing values of humanity. In this context, we refer to the philosophical and political principles guiding the activities of DIGNITAS⁴⁵ which we feel may well serve as a basis for any consideration of end-of-life-issues.

⁴⁵ See the booklet/brochure „How DIGNITAS works“, available online: http://www.dignitas.ch/index.php?option=com_content&view=article&id=23&Itemid=84&lang=en

7) Conclusion

“No one shall set upon a long journey without having thoroughly said goodbye to loved ones and no one shall set upon such journey without careful preparation”. At a time in which lonely, unassisted suicides among older people, in particular, are increasing sharply – as a result of the significant increase in life expectancy and the associated health and social problems of many men and women who have become old, sick and lonely – careful and considered advice in matters concerning the voluntary ending of one’s own life is gaining relevance. Furthermore, developments in modern medical science have also led to a significant prolonging of life. Yet, there are individuals who explicitly would like to add life to their years – not years to their life.

It is about time that law makers respect the will of the people and implemented sensible solutions that allow individuals, who so choose, to have a dignified, self-determined end to life at their own home, surrounded by those close to their hearts.

In the light of this, DIGNITAS very much welcomes and supports the efforts and work put into the Assisted Suicide (Scotland) Bill and hopes it finds a majority of open ears and minds in Parliament.

We close these considerations with words by DAVID HUME, one of the most famous philosophers of the last 300 years, born and died in Edinburgh⁴⁶:

„If Suicide be supposed a crime, 'tis only cowardice can impel us to it. If it be no crime, both prudence and courage should engage us to rid ourselves at once of existence, when it becomes a burthen. 'Tis the only way, that we can then be useful to society, by setting an example, which, if imitated, would preserve to every one his chance for happiness in life, and would effectually free him from all danger of misery.“

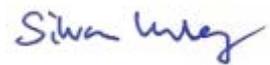
Yours sincerely

DIGNITAS

To live with dignity - To die with dignity
Secretary General



Ludwig A. Minelli



Silvan Luley

⁴⁶ DAVID HUME, Of Suicide, <http://ebooks.adelaide.edu.au/h/hume/david/suicide>, in fine