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# **The Proposed End of Life Choices (Scotland) Bill**

Consultation Document  
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## Foreword

The proposal that persons who wish to decide when to end their lives should be able to do so, legally, with the assistance of a registered physician has come about because of the experiences of people with degenerative conditions, terminal illnesses and those who become entirely dependent on others following a trauma.

Although suicide – self-inflicted death – is not a crime, it is illegal in Scots Law for assistance to be given to end a life, even if that help is requested by the person wishing to die.

This appears to be inequitable as it is legal for a person to instruct that no resuscitation should be attempted following an illness, trauma, stroke or coma etc. The motivation for this instruction, given while the person concerned is capable of making such a judgement (a Living Will), is the person's wish to shorten a life that they would judge intolerable.

Why should it be legal for a person to exercise autonomy, and refuse treatment from a physician to preserve his or her life, yet illegal for a physician to respond to a request for medication that would have the same result in ending a life that the person concerned judges to be intolerable?

For some people the question is irrelevant because they believe God determines when life ends, and nothing that is proposed will compromise their belief. But our society embraces many people who do not share this belief, who believe in the autonomy of the individual in taking responsibility for, and exercising choice over how life is lived, including the end of life.

This much has emerged through the publicity surrounding several recent cases of people seeking legal assurances that penalties will not be invoked against anyone assisting them to end their lives because, for example, a degenerative condition has made life intolerable.

Following the attempt by Jeremy Purvis to introduce a Member's Bill on assisted dying, public interest in the matter has become obvious. Radio listener phone-in programmes, readers' letters pages in newspapers, internet exchanges and the sheer volume of communications, from all parts of the country, with my parliamentary office are testimony to a desire for clarity in the law on seeking assistance to end one's life.

These communications indicate a desire to debate the concept of patient "autonomy," even where people may not have arrived at a fixed opinion. Allied to this, my correspondence indicates no conflict of interest between the desire for palliative care to be available near the end of life, and the recognition that for some people, it will not meet their need if life has become intolerable, either because of pain, or through loss of function or some other reason.

Therefore, with the assistance of Christina Chen, Peter Warren and the Scottish Parliament's Non-Executive Bills Unit, I have launched this consultation and will seek the support of 18 MSPs to introduce a Bill on End of Life Choices. This procedure will allow the matters referred to above and in the following pages to be properly investigated and scrutinised by the Scottish Parliament.

Obviously, in a pluralistic society such as Scotland, there will be differing beliefs and opinions on this question. It sits at the interface of private morality, public policy and the law. But there are ambiguities and a lack of clarity around the issue that, at the very least, indicate the need for examination of our current law and practices.

# The Proposed End of Life Choices Bill

## 1. Objective of the Proposed Bill

The purpose of the proposed bill is to clarify the laws in Scotland relating to the assistance given to end the life of a person requesting such help before death would occur naturally. At present, neither statute nor case law clarify the circumstances in which it would be legal to provide assistance on the request of someone wishing to end his or her life.

The bill would propose that, on the request of the patient, and conditional on legal requirements being adhered to, a physician assisting a “patient” to die will not be guilty of an illegal act.

A patient’s right to end of life choices is based on the principle of autonomy, that a person has the right to determine the quality of his or her own life and its value, unrestricted by the moral, cultural, religious, or personal beliefs of others.

It is important to note that the proposed bill is consistent and compatible with palliative care as an important part of comprehensive end of life care; the proposed bill does not see palliative care and end of life options as mutually exclusive but rather, as complementary choices.

The Scottish Government recently published the *Living and Dying Well: National Action Plan for Palliative and End of Life Care in Scotland (Sept. 2008)* to address major improvements to palliative care.<sup>1</sup> That action plan aims to provide an effective, more comprehensive system of palliative care by June 2010. However, there is no discussion on end of life choices related to assisted dying. Thus, the proposed bill would continue where that consultation left off.

## 2. Proposal for a Bill to Permit Physician Assistance to Persons Who Wish To End Their Own Lives

The definitions of terms used in this consultation are explained on page 17.

### 2.1 Applicability

This proposed bill applies to capable adults who are residents of Scotland.

**Q1: What are your views on applicability requirements?**

### 2.2 Capability

The *Adults with Incapacity (Scotland) Act 2000* defines an “adult” as someone who has reached the age of 16 years.

“Incapable” means incapable of –

- Acting; or
- Making decisions; or
- Communicating decisions; or
- Understanding decisions; or
- Retaining the memory of decision,

by reason of mental disorder or of inability to communicate because of physical disability; but a person will not fall within this definition by reason only of a lack or deficiency in a faculty of communication if that lack or deficiency can be made good by human or mechanical aid (whether of an interpretative nature or otherwise).”<sup>2</sup>

If the attending physician doubts the mental capacity of a “patient” to make and communicate health care decisions to health care providers, the “patient” would be evaluated by a consulting health professional. The proposed bill will use the statutory definitions to determine if someone is capable, but I will invite comment on the age at which a patient might be judged capable of requesting assistance to die.

The age at which capability might be recognized, and a patient’s autonomy exercised, has been highlighted by Hannah Jones, a 13-year-old, terminally ill leukaemia patient who won the right to refuse treatment rather than undergo a risky heart transplant. She was informed by doctors that the operation could kill her or make her more susceptible to

other forms of leukaemia, but that it was her only chance of survival. Diagnosed with a rare form of leukaemia at age 4, Hannah has been through chemotherapy and undergone more than ten operations.

“I have had too much trauma. I didn’t want this [a heart transplant] and it’s not my choice to have it. I have made the right decision at the moment and I’m not going to change it,” she said.

After her decision to refuse the transplant, Hereford Hospital began High Court proceedings in an attempt to remove her temporarily from her parents’ custody to force the transplant. The High Court in England eventually decided that Hannah was mature enough to decide for herself.

“My parents have always encouraged me to make my own decisions. When it comes to my heart, I’d much rather do things my way than have other people decide for me,” she said.<sup>3</sup>

**Q2: From what minimum age should a person be able to specify an end of life choice? Please give reasons for your answer.**

### **2.3 Proposal**

The process of physician assisted dying would be initiated by the “patient.” A request would be made for assistance from a suitably registered and qualified attending physician to bring the patient’s life to an end should it become intolerable to the “patient.” Usually agreement would be concluded between the attending physician and the patient, when his or her general health is still reasonable. To activate the process of assisted dying, two requests for assistance would be made, at least 15 days apart. The attending physician would seek a second opinion from a consulting health professional as to the patient’s capability if necessary. If the attending physician is incapacitated and unable to carry out a patient’s wishes, the “patient” would have the right to approach another suitably qualified attending physician. Post-mortem, the attending physician would be required to request a review committee verify that the specified criteria and safeguards had been observed.

The bill proposes that patients enjoying otherwise satisfactory health but with degenerative, irreversible conditions would make their wishes known to an attending

physician, qualified and registered as someone willing to help terminate life at the patient's request.

"Patients" who unexpectedly become incapacitated to a degree they find intolerable could initiate the same process.

"Patients" who are not terminally ill, suffering from a degenerative condition, or unexpectedly incapacitated but who find their life to be intolerable may request assistance to end it from a suitably qualified and registered attending physician. In this case, the attending physician must seek a second opinion from a suitably qualified consulting health professional.

#### **2.4 Waiting Period between Requests**

A capable "patient" must submit an initial valid and documented request to an attending physician and then submit a second valid and documented request no earlier than 15 days after the initial request so as to reflect a genuine desire to end his or her life. Patients may rescind their request at any time.

**Q3: Do you feel a waiting period of 15 days is enough? If not, what would be a sufficient waiting period and why?**

**Q4: Do you have a view on what constitutes a "valid and documented request"?**

#### **2.5 Attending Physician Responsibilities**

The attending physician should:

- (a) Make or have made the initial determination, in writing, that the "patient" is capable and has made the request voluntarily;
- (b) Inform the "patient" of his or her medical diagnosis, his or her prognosis, and the potential risks associated with taking the medication to be prescribed;
- (c) Inform the "patient" of all feasible alternatives, including but not limited to, hospice care and palliative care;
- (d) Inform the "patient" that he or she may rescind the request to terminate life at any time and in any manner, even after the 15 day waiting period; and
- (e) Report the case to the review committee and provide patient's medical record documentation requirements if assistance has been given to terminate the patient's life. See Section 5.

**Q5: Are there any other responsibilities you would add to the responsibilities of the attending physician?**

## 2.6 Consulting Health Professional Responsibilities

The consulting health professional should:

- (a) Examine the “patient” and confirm, in writing, that the “patient” is capable and has made the request voluntarily; and
- (b) Confirm the “patient” is aware of all feasible alternatives, including but not limited to, hospice care and other palliative care.

**Q6: Are there any other responsibilities you would add to the responsibilities of the consulting health professional?**

## 2.7 Conscientious Objection

In carrying out a patient’s end of life wishes, the attending physician with a conscientious objection shall not be compelled to participate or continue assistance. If, when the “patient” requests assistance to bring his or her life to an end, the original attending physician is unable to assist, the “patient” would have the option to approach another suitably qualified attending physician.

# 3. Current Law and Inconsistencies

## 3.1 Current Scots Law

Scots law states that suicide is not a crime. However, assisting in another’s suicide is a different matter that is not specifically covered by legislation. According to *Scots Criminal Law (1997)*,

“Suicide is not a crime in Scots Law and it is therefore not a criminal offence to attempt suicide. Encouraging or assisting another to take his own life is another matter, as the sympathy which the law has for the suicide does not necessarily extend to those who facilitate suicide. There is no Scottish authority on this issue; in other jurisdictions it is not unusual to find statutory provisions which penalise the provision of any assistance to the would-be suicide.”<sup>4</sup>

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

“Under Scots law, an act of euthanasia by a third party, including physician-assisted suicide, is regarded as the deliberate killing of another and would be dealt with under the criminal law relating to homicide. The consent of the victim would not be a defence and no degree of compassion on the part of the person who carried out the act would amount to a legal justification.”<sup>5</sup>

In England and Wales, suicide is not a crime according to the *Suicide Act of 1961*. However,

- “A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years.
- If on the trial of an indictment for murder or manslaughter it is proved that the accused aided, abetted, counselled or procured the suicide of the person in question, the jury may find him guilty of that offence.”<sup>6</sup>

The *Suicide Act of 1961* does not define what it means to aid or abet the suicide of another. This gap in the law has recently been highlighted by the dilemma faced by people with degenerative conditions who wish to use the service offered by Dignitas when their condition deteriorates to the point at which life comes intolerable to them.

Dignitas is a Swiss-based service provides the location and the means by which people can self-administer a fatal, coma-inducing drug. There is a rigorous examination of the applicant’s motivation, physical and mental health etc. in the forms that require to be completed and accepted by Dignitas before the journey to Switzerland. This represents a potential conflict with UK law arising out of the patient’s need for help in completing application forms, preparation and travel to Switzerland. There is a need to protect from possible legal action the person assisting with form-filling or travel arrangements.

In England, Debbie Purdy, who has a fast-degenerating condition, has tried to protect her husband by going to the High Court for a ruling (see Case Studies). The judgement confirmed that such law is the responsibility of Westminster. In Scotland this area of law is devolved to Holyrood.

Although there are slight differences of approach between Scots and English law on assisted dying, it would appear that public attitudes towards it are very similar. Polling conducted in the UK confirms this.

- A YouGov survey (May 2006) asked the following question: “Do you think the law should be changed to allow such patients to receive a prescription from their doctor to end their suffering, subject to a range of safeguards?” 76% of total respondents agreed, whilst the Scottish figure was 78%.<sup>7</sup>
- A ICM survey (March 2006) asked the following question: “Do you think that, provided there are strict safeguards, if a competent terminally ill person asks for it, a doctor should ever be allowed by law to prescribe for the patient life-ending medication that the patient then takes to end his or her own life?” 71% of total respondents agreed, whilst the Scottish figure was 83%.<sup>8</sup>

### **3.2 Do Not Attempt to Resuscitate (DNAR) Policies**

Currently, patients have the right to request that they are not to be resuscitated and to refuse additional life-preserving medication, as stated for example in the *2007 NHS Lothian Do Not Attempt to Resuscitate (DNAR) Policy*.<sup>9</sup> Additionally, doctors are allowed to withdraw medication for patients in a persistent vegetative state. In such cases, the wishes of family members become a part of the decision-making process.

By way of contrast, patients with an irreversible illness or condition, whose death is expected in the near-future, who may be in extreme pain or for some other reason judge their life to be intolerable, cannot make the same decision to end their lives before death occurs naturally, as could their relatives and physicians could if the person was incapacitated.

The bill proposes to end this inconsistency by enshrining in Scots Law the principle of patients’ autonomy.

## **4. Case Studies**

### **4.1 Val McKay**

Val McKay is a 41 year old woman, living alone with carers, in an adapted flat in Perth, who suffers from a rapidly-progressing degenerative condition. She is unable to move

without assistance and a sling is used to transfer her from her bed to her wheelchair. Much to her anguish and concern, she is losing strength in her upper limbs and fears that she will not be able to manage to hold and drink from the cup containing the barbiturate in the Dignitas facility. The Swiss law demands that patients must only be “assisted” and not simply have the drug administered to them.

Val considers her life lost all meaning and purpose some time ago and she wishes to end it rather than endure for a few months more the mental, emotional and physical stress that characterise her existence.

#### **4.2 The Bowman Family**

The Bowman family, from Cumbernauld, is a reminder of how the present uncertainty surrounding the exercise of autonomy by people choosing to end their lives can affect their family members, and others.

Mrs Bowman suffered from Parkinson’s and gradually became unable to perform even the most uncomplicated functions. She was totally dependent on others, mainly her husband.

She explained to her children, with their father present, that her life had become intolerable and that with her husband’s help, she planned to end it rather than endure what she saw as meaningless torture.

Her children respected her decision, and their father’s agreement to co-operate with it. Mrs Bowman’s death took place in her home by means of a combination of drugs and possibly, suffocation. Her death certificate did not record her death as having been due to suicide or assisted suicide, and her children and husband never discussed how Mrs Bowman’s life had ended.

#### **Case Studies from England**

Arguably, these cases have influenced opinion in Scotland.

#### **4.3 Dan James**

Dan James, a promising 23-year-old rugby player, was paralyzed in a training ground accident in March 2007. Described by friends as “an aware, intelligent, strong-willed and

determined” young man, the front-row forward had a likely future as a professional rugby player. As a quadriplegic, Dan found his life intolerable and described it as a “second class existence”; he attempted suicide three times and finally resorted to starving himself.

“He couldn’t walk, had no hand function, but constant pain in all of his fingers. He was incontinent, suffered uncontrollable spasms in his legs and upper body and needed 24-hour care,” said his mother.<sup>10</sup>

18 months after his accident, Dan determined to end his life. In September 2008, he traveled with his parents to Dignitas. His parents are now under investigation by the Crown Prosecution Service for assisting their son in his decision to end his life.

#### **4.4 Diane Pretty**

In 2001, Diane Pretty, a terminally ill patient with motor neurone disease, fought for the legal right to request medical help to terminate her life in the last stages of her condition. She also requested reassurance from the courts that her husband would not be prosecuted for assisting her in obtaining medical help. Diane Pretty was well aware that in the last stages of her condition, she would slowly become paralyzed while her brain still functioned, waiting only for a slow and painful death by choking and suffocation.

Suicide is not a crime, but her condition had made it impossible for her to take her own life in the final stages. Thus, she needed the aid of her husband. But without any clarification or assurance from the public prosecutor, her husband could have faced prosecution for aiding a suicide, an offence that carries on conviction a prison term of up to 14 years.

“I want to have a quick death without suffering, at home surrounded by my family so that I can say good-bye to them,” she wrote, on her website.

She fought for a year, appealing to the High Court in England, the House of Lords, and finally to the European Court of Human Rights. In April 2002, the European Court dismissed Ms. Pretty’s request for the legal right to medical help to terminate her life, stating that refusal to allow her to die did not violate her human rights.

“The law has taken all my rights away,” she said after the ruling. Paralyzed from the neck down, Ms. Pretty spoke with the aid of a computer.

Diane Pretty died three days later, after slipping into a coma due to severe breathing problems caused by motor neurone disease.<sup>11</sup>

“Diane had to go through the one thing she had foreseen and was afraid of – and there was nothing I could do to help,” said her husband, Brian Pretty.

Over 50,000 people signed her petition for a change in the law to permit assisted dying.<sup>12</sup>

#### **4.5 Debbie Purdy**

Debbie Purdy, who has primary progressive multiple sclerosis, appealed to the High Court in England in October 2008 to clarify the circumstances under which assisted suicide is illegal. She plans to travel to Dignitas in Switzerland to end her life should her condition become intolerable, but wishes to ensure her husband will not be prosecuted for assisting her. Ms. Purdy requested that the Director of Public Prosecutions clarify the circumstances under which assisting with a suicide is a punishable crime. Her situation brings attention to concerns about the limits of “assisting” a suicide. Is it packing a bag or driving a patient to hospital, for example?

“Because it’s so unclear, we don’t know what my husband can do,” she said.

“My dearest wish would be to die with dignity in my own home, with my husband and other loved ones around me. I hate the idea of having to travel to another country when I will be at my weakest and most vulnerable, both emotionally and physically,” said Ms. Purdy.

“Going to another country also means that I have to go earlier, because being able to travel such a distance and to make all the arrangements in a foreign country will require me to be physically and mentally capable so that too will mean that my life is further shortened as a result of the lack of a humane law in this country. I hope that one day the law will recognise that this is inhumane and that the law should be changed,” she concluded.<sup>13</sup>

On 29 October 2008, Debbie Purdy lost her legal battle for clarification of the circumstances under which assisting another person to end his or her life is a crime.

Judges ruled that the current Code of Practice for Crown Prosecutors is clear and sufficient, adding that

“[assisted suicide] would involve a change in the law. The offence of suicide is very widely drawn to cover all manner of different circumstances; only Parliament can change it.”<sup>14</sup>

#### **4.6 The Need for Change**

To date, Dignitas in Switzerland has helped 101 Britons end their lives.<sup>15</sup> About 560 of its members (13%) are UK residents, some of whom are Scots.<sup>16</sup> However, patients should not have to face the additional stress and worry of traveling internationally and leaving the comfort of home. In addition, the financial cost of such a trip can often be prohibitive. The proposed bill would address the needs of people in situations like those of Val McKay, the Bowman family, Dan James, Diane Pretty and Debbie Purdy and provide them with an additional option at the end of life to conclude good palliative care.

## **5. Safeguards in the Proposed Bill**

### **5.1 Reporting Criteria**

Post-mortem, the attending physician would be required to notify the review committee and submit all relevant medical record documents without delay.

### **5.2 Medical Record Documentation Requirements**

The patient’s medical record to be reported to the review committee will include:

- (a) All properly recorded requests made by the “patient” for assistance to end his or her life;
- (b) The attending physician’s written diagnosis and prognosis of the patient, and the determination that the “patient” is capable and acting voluntarily;
- (c) Any additional reports by any consulting health professionals confirming the “patient” is capable and verification that the “patient” is acting voluntarily; and
- (d) All other documents in the patient’s medical records.

### **5.3 The Review Committee**

The proposed bill will exempt registered attending physicians from criminal liability if they report their actions and prove that they have satisfied criteria as laid out in Section 4. The exact composition of this review committee will be left to Scottish Ministers to

determine. This review committee would be required to assess each individual case to determine whether the attending physician has satisfied the criteria outlined above. If the committee is not convinced or feels additional investigation is required, the case will be turned over to the Procurator Fiscal.

Assisting someone to die will remain a criminal offence unless the procedures as set out are complied with.

**Q7: If the proposed Bill did not specify a review committee, do you have any views on alternative arrangements or safeguards?**

## **6. End of Life Choices in Other Countries**

Assisted dying is a difficult and emotive subject. For many, a right to end of life choices is vital to their sense of dignity and autonomy. As a result, a number of countries have amended their laws to provide alternative end-of-life choices for those who find their lives to be intolerable.

~~With regards to choices for the end of life, there are many ethical and practical arguments for and against allowing assisted suicide. The issue is complicated by those who have momentary lucidity and capability.~~

### **6.1 USA**

#### ***US State of Oregon***

The Oregon Death with Dignity Act (1997) rests on the right of terminally ill patients to obtain from their physicians a prescription for sufficient medication to end life after patients self-administer the prescribed drug.

Physicians, and others, are precluded from administering the prescription to the patient, nor can the physician or others administer any other lethal drug, even if requested by the patient to do so. Neither can a physician decide to terminate a patient's life without a request from the patient.

Only the patient can make the request for a prescription: in the event of the patient being incapable of making a request, family members, for example, cannot request a prescription on the patient's behalf.

Before a prescription is issued, the patient must be terminally ill with a life expectancy of six months or less, have made two requests separated by 15 days, be of legal age and capability and a resident of Oregon.

The Act was brought about by a Citizens' Initiative in 1994 but did not come into effect after it was endorsed by 60% of those voting in a second referendum 3 years later.

The Oregon Department of Human Services publishes annual statistics, and monitors cases to safeguard against irregularities or illegalities. Interestingly, only approximately half of those prescribed lethal medication use it.

### ***US State of Washington***

In November 2008, the US State of Washington became the second state to legalise assisted dying for the terminally ill, passed by a citizen's initiative. The proposed Washington model is identical to the Oregon Death with Dignity Act (1997) described below. Washington is the most recent addition to the number of countries/territories that have decriminalized assisted dying.

## **6.2 The Netherlands**

Dutch law allows for voluntary euthanasia, but only when the physician is requested by the patient to administer a drug that will end the patient's life. The Termination of Life on Request and Assisted Suicide (Review Procedures) 2002 aims to ensure the process is transparent and not abused, and serves the best interests of patients. This Act defined and clarified in statute what had been common practice in the Netherlands for twenty years.

The 2002 Act requires physicians to demonstrate knowledge and understanding, acquired over a considerable time, of patients who request assistance to end lives have become intolerable for them. Euthanasia on request can be sought at 16 years autonomously, and with parental or guardian consent from the age of 12 years.

The substantive requirements of the 2002 Act are:

- That the "patient" makes a voluntary, well-considered request;
- The "patient" is well-informed of his diagnosis;
- The wish for death is durable and persistent;
- The "patient" is in unacceptable suffering;
- The "patient" has been informed of all alternatives;
- Two physicians agree on the proposed course of action; and
- The death is reported.

Post mortem, Assessment Committees review the patient's history, confirm that procedures have been in order and that the patient has not been subjected to pressure or manipulation. Discrepancies are notified to the public prosecution service and the health board.

Annually, requests for euthanasia total approximately 9,700. Of the approx. 3,800 who are helped to die, 300 self administer drugs supplied by their physician. Dutch opinion appears to strongly support the provisions of the 2002 Act, under which assisted dying comprises 2.8% of all deaths, with self-administration accounting for 0.2% and requested euthanasia accounting for 2.6% of assisted deaths.<sup>17</sup>

### **6.3 Switzerland**

Switzerland has allowed altruistic assisted suicide since 1941, but specifically prohibits euthanasia. Article 115 of the Criminal Code specifies that assisted suicide is punishable when there is a selfish motive. When motivated by altruism, however, assisted suicide is not a criminal act. There is no requirement for the involvement of a physician, nor is assisted suicide restricted to terminally ill patients. Currently, three organizations in Switzerland assist terminally ill people with support and counseling, and by making lethal medication available, usually a lethal amount of barbiturate in a drink. In reporting an assisted suicide, the description of cause is “unnatural death.” Swiss law does not judge assisted suicide to be irrational or illegal.

Over the past decade, Switzerland has become the most well-known location for “suicide tourism.” Most jurisdictions, like Scotland and England, have not legalised assisted suicide; as a result, increasing numbers of people are choosing to travel to Switzerland to exercise their end of life choice.

To date, 101 UK citizens have traveled to the Swiss Dignitas clinic to end their lives. Over the past 10 years, 870 people from different countries have sought the help of Dignitas.<sup>18</sup>

### **6.4 Belgium**

Belgium legalised euthanasia in 2002 following the Netherlands, becoming the second country in Europe to do so. The *Belgian Act on Euthanasia of May, 28th 2002* defines euthanasia as “an act of a third party that intentionally ends the life of another person at

that person's request." Euthanasia administered by doctors is preferred because physicians can deal with complications that can arise that non-physicians may be ill-equipped to resolve.

In addition to other safeguards, the Act stipulates that doctors must report each case, which is then reviewed by a commission. Patients must be at least 18 years of age to qualify for assisted suicide. Two doctors must be involved, as well as a psychiatrist if the patient's competency is in doubt. The doctor and "patient" negotiate whether death is to be by lethal injection or prescribed overdose.<sup>19</sup>

In the first two years of the Belgian law legalizing euthanasia, just over 500 cases were reported. In the first 15 months there were just 259 cases. This represented 0.2% of the estimated total deaths in Belgium during that period.<sup>20</sup>

### **6.5 Luxembourg**

On 20 February 2008, the Luxembourg Parliament passed a Euthanasia Bill on its first reading. The Bill will be legalised if it passes a second reading later this month in December 2008. If passed, it would come into effect 1 January 2009. The Bill would allow terminally ill patients to end their lives if they made repeated requests and had the consent of two doctors and a panel of experts. Luxembourg would become the third EU country to legalise euthanasia.

## **Consultation Questions:**

Q1: What are your views on applicability requirements? (p.3)

Q2: From what minimum age should a person be able to specify an end of life choice? Please give reasons for your answer. (p.4)

Q3: Do you feel a waiting period of 15 days is enough? If not, what would be a sufficient waiting period and why? (p.5)

Q4: Do you have a view on what constitutes a “valid and documented request”? (p.5)

Q5: Are there any other responsibilities you would add to the responsibilities of the attending physician? (p.5)

Q6: Are there any other responsibilities you would add to the responsibilities of the consulting health professional? (p.6)

Q7: If the proposed Bill did not specify a review committee, do you have any views on alternative arrangements or safeguards? (p.13)

**You are invited to make further comment on the proposals in the consultation document. (see page 19)**

## Definitions of Terms Used in this Consultation

**These definitions are for the purposes of this consultation document. They may differ from legal terms or definitions:**

**Attending physician** – ordinarily, the general practitioner or physician who has primary responsibility for care and treatment of the “patient” but may be another suitably qualified health professional.

**Capability** – in the opinion of the court or in the opinion of the patient’s attending physician or consulting health professional, a “patient” has the ability to make and communicate health care decisions.

**Consulting health professional** – a health professional who is qualified by specialism or experience to make a professional diagnosis and/or prognosis regarding the patient’s condition.

**Dignitas** – non-profit Swiss organization based in Zurich that provides the means by which patients may choose to terminate their lives. A qualified physician provides a lethal dose of barbiturates which the patient must drink independently.

**Palliative care** – an approach that improves patient quality of life through the effective relief of pain and suffering, taking into consideration religious, spiritual and cultural circumstances. Palliative care focuses on the individual rather than the illness, enabling a person to live with a progressive or terminal illness; it is not restricted to the end of life.

**Physician assisted dying**– on request of the patient, a medical practitioner administers a lethal dosage of medication to terminate a patient’s life, or supplies the means and assists the patient to self-administer. Also known as physician assisted suicide.

**Terminal illness** – an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.

## **How to Respond**

You are invited to read these proposals, and comment on any issues that you feel may be relevant. **Responses must be submitted by 9 March 2009**, and should be sent to the following address:

Margo MacDonald MSP  
The Scottish Parliament  
Edinburgh  
EH99 1SP

Alternatively, please email responses to

[margo.macdonald.msp@scottish.parliament.uk](mailto:margo.macdonald.msp@scottish.parliament.uk)

Telephone: 0131 348 5714

Fax: 0131 348 6271

In addition, please pass this consultation document on to any other interested parties that you may be aware of.

Additional copies of the paper or alternative formats can be requested using the contact details above and calls via Typetalk are welcome. Further copies of this consultation paper are available from the above address. It can also be downloaded from the Scottish Parliament website at:

<http://www.scottish.parliament.uk/s3/bills/MembersBills/index.htm>

To help inform debate on the matters covered by this paper and in the interests of openness it is intended all the responses submitted on this consultation document will be made public. You should therefore be aware that by submitting this response you are indicating consent to the publication of all the material contained in your response. Unless you indicate otherwise this will include your name and address and any other biographical information you have provided about yourself.

You should note that personal data referring to third parties included in the response cannot be accepted without explicit written consent from the third party. This consent should be provided with your response.

We are not entitled to process your personal data by publication without your consent. If therefore you want parts of your response to remain confidential please indicate which

parts are not for publication. Similarly, if you wish all of the contents of your response to be treated in confidence and not made public then please indicate so.

All responses will be included in any summary or statistical analysis, which does not identify individual responses.

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