

# DIGNITAS

To live with dignity

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## Proposal for an Assisted Suicide (Scotland) Bill

### Response to the Consultation by “DIGNITAS - To live with dignity - To die with dignity”, Forch, Switzerland

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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”<sup>1</sup> These are not the words by a protagonist of the many organisations

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<sup>1</sup> In: Epistulae morales LXX ad Lucilium

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 2011<sup>2</sup> 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 “FATE - Friends At the End” in Glasgow.

In Switzerland, 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. Later, associations like EX INTERNATIONAL, DIGNITAS and SUIZID-HILFE followed, the only difference between these organisations being mainly the acceptance or not of members residing in countries other than Switzerland.

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

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 over 58,000 members, EXIT-A.D.M.D. 16,700 and EX INTERNATIONAL approximately 700 members. DIGNITAS, together with its independent German partner association DIGNITAS-Germany in Hannover, counts over 6,000 members worldwide of whom almost 900 reside in the U.K.<sup>3</sup>

In the almost 14 years of DIGNITAS’ existence, 182 members of DIGNITAS residing in the U.K. – of whom 9 lived in Scotland – have made use of the option of an accompanied suicide in Switzerland<sup>4</sup>. 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 rest of the U.K., 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 2010<sup>5</sup>, 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.

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.”

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<sup>3</sup> <http://www.dignitas.ch/images/stories/pdf/statistik-mitglieder-wohnsitzstaat-31122011.pdf>

<sup>4</sup> <http://www.dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2011.pdf>

<sup>5</sup> [http://www.cps.gov.uk/publications/prosecution/assisted\\_suicide\\_policy.pdf](http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.pdf)

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 EXIT, DIGNITAS and others.

DIGNITAS very much welcomes Margo MacDonald's proposal for a Bill to enable a competent adult with a terminal illness or condition to request assistance to end their own life, and to decriminalise certain actions taken by others to provide such 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 8<sup>th</sup>, 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"<sup>6</sup>. 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 29<sup>th</sup>, 2002<sup>7</sup>, 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 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:

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<sup>6</sup> Convention for the Protection of Human Rights and Fundamental Freedoms, page 5, available online: [http://www.echr.coe.int/NR/rdonlyres/D5CC24A7-DC13-4318-B457-5C9014916D7A/0/CONVENTION\\_ENG\\_WEB.pdf](http://www.echr.coe.int/NR/rdonlyres/D5CC24A7-DC13-4318-B457-5C9014916D7A/0/CONVENTION_ENG_WEB.pdf)

<sup>7</sup> Application no. 2346/02; Judgment of a Chamber of the Fourth Section, available online: <http://cmiskp.echr.coe.int/tkp197/view.asp?action=html&documentId=698325&portal=hbk&source=externalbydocnumber&table=F69A27FD8FB86142BF01C1166DEA398649>

“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 3<sup>rd</sup>, 2006, the Swiss Federal 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.”<sup>8</sup>

In that decision, the Swiss Federal 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.”

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

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<sup>8</sup> BGE 133 I 58, page 67, consideration 6.1. To be found on-line: <http://www.bger.ch/index/jurisdiction/jurisdiction-inherit-template/jurisdiction-recht/jurisdiction-recht-leitentscheide1954.htm>

Swiss Federal 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 20<sup>th</sup>, 2011, the European Court of Human Rights rendered a judgment<sup>9</sup> 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 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 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.

There are further cases pending at the said Court which rest upon this very issue of which one, the case of ULRICH KOCH against Germany, has been declared admissible on May 31<sup>st</sup>, 2011<sup>10</sup>. In this case, 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 commit suicide at her home.

In light of the fact that the Court confirmed the judgment of the Swiss Federal Court, declared admissible the case of Mr. Koch 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.

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 problem will present itself increasingly within the Convention's jurisdiction, due to demographic developments.

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<sup>9</sup> Application no. 31322/07; Judgment of a Chamber of the First Section (in French), available online: <http://cmiskp.echr.coe.int/tkp197/view.asp?action=html&documentId=880260&portal=hbkm&source=externalbydocnumber&table=F69A27FD8FB86142BF01C1166DEA398649>

<sup>10</sup> Application no. 479/09, Judgment of the Former Fifth Section, available online: <http://cmiskp.echr.coe.int/tkp197/view.asp?action=html&documentId=886317&portal=hbkm&source=externalbydocnumber&table=F69A27FD8FB86142BF01C1166DEA398649>

We would like to emphasize that in this context, since the case of *ARTICO v. Italy* (judgment of May 13<sup>th</sup>, 1980, series A no. 37, no. 6694/74<sup>11</sup>), the developed 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; . . .”

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 Court 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.<sup>12</sup>

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.

Until now, national and international debates on assisted suicide and 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.

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<sup>11</sup> To be found online: <http://cmiskp.echr.coe.int/tkp197/view.asp?action=html&documentId=695301&portal=hbk&source=externalbydocnumber&table=F69A27FD8FB86142BF01C1166DEA398649>

<sup>12</sup> 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>

In the year 2010 there were, in Scotland, 781 registered suicides (deaths which are the result of intentional self-harm or events of undetermined intent)<sup>13</sup>; the total for the U.K. was 5,608<sup>14</sup>.

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 rate<sup>15</sup>. 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 9<sup>th</sup> 2002<sup>16</sup>: 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 39,050 per year; for the whole U.K. up to 280,400. 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 7,810 suicide attempts in Scotland and 56,080 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:

- 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;

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<sup>13</sup> Publications by the General Register Office for Scotland, to be found online: <http://www.scotland.gov.uk/Resource/Doc/328405/0106170.pdf>

<sup>14</sup> Publications of the Office for National Statistics, to be found online: <http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Suicides+and+Intentional+Self-harm>

<sup>15</sup> Report on the consultation on preventing suicide in England, p. 2, to be found online: [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_128463.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128463.pdf)

<sup>16</sup> Online (in German): [http://www.parlament.ch/d/suche/seiten/geschaefte.aspx?gesch\\_id=20011105](http://www.parlament.ch/d/suche/seiten/geschaefte.aspx?gesch_id=20011105)

- 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.)<sup>17</sup>

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 from such inhumane treatment in cases of assisted dying. There is room to look into this aspect more closely in future cases<sup>18</sup>.

#### **4) Suicide prevention – experience of DIGNITAS**

Everyone should be able to discuss the issue of suicide openly with their General Practitioner, psychiatrists, carers, etc. The taboo which surrounds the topic must be lifted. The possibility of – anonymously as well as openly – using a

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<sup>17</sup> See the study of PETER HOLENSTEIN: <http://www.dignitas.ch/WeitereTexte/Studie%20Suizidkosten.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.

<sup>18</sup> 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.

help-line is a very important service provided by some institutions<sup>19</sup>. 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 almost 14 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 absurd: 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 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.

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<sup>19</sup> In Scotland provided for example by The Samaritans, see [http://www.samaritans.org/talk\\_to\\_someone/find\\_my\\_local\\_branch/scotland.aspx](http://www.samaritans.org/talk_to_someone/find_my_local_branch/scotland.aspx)

Knowing about a ‘real’ option will deter many from 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 Oregon<sup>20</sup> – 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”<sup>21</sup>. 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 cumulative 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 nation-

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<sup>20</sup> 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/deathwithdignity/act/pages/ar-index.aspx>

<sup>21</sup> 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>

wide 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")<sup>22</sup>: 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 to perform 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 two assisted suicides per year have taken place since the authorities allowed associations like EXIT, DIGNITAS and others to access such homes in 2002.

The issue is not whether someone would take advantage 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

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<sup>22</sup> in: FRANK TH. PETERMANN, (ed.), Sicherheitsfragen der Sterbehilfe (Safety questions in assisted dying), St. Gallen 2008, p. 125-146

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'<sup>23</sup> 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 time<sup>24</sup>. 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 suicidal human being, offers more sophisticated results than solutions 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 report<sup>25</sup>, the situation is in fact a disgrace. 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, a further unacceptable discrimination.

Clearly, the public is in favour of freedom of choice in these 'last issues'<sup>26</sup>. 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.

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<sup>23</sup> 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>

<sup>24</sup> Extract of the study (available in German) online: <http://www.dignitas.ch/images/stories/pdf/studie-mr-weisse-dossier-prozentsatz-ftb.pdf>

<sup>25</sup> See online: <http://www.demos.co.uk/publications/thecommissiononassisteddying>

<sup>26</sup> 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 and others.

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 quo<sup>27</sup>.

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 Margo MacDonald's proposal for a Bill to enable a competent adult with a terminal illness or condition to request assistance to end their own life, and to decriminalise certain actions taken by others to provide such assistance.

Based on experience drawn from almost 14 years of operating, DIGNITAS very much adheres to Margo MacDonald's statement 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 spiritual<sup>28</sup>. 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 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 al-

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<sup>27</sup> 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](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).

<sup>28</sup> Definition by the World Health Organisation, see online: <http://www.who.int/cancer/palliative/definition/en>

ways 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 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 quadriplegics<sup>29</sup> or patients suffering from a multitude of ailments related to old age<sup>30</sup> are generally not *per se* eligible for palliative care and terminal sedation because they are not suffering from a life-threatening illness as such. These 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 usually applied in end-of-life palliative care. Without doubt, such patients are experiencing severe suffering which can lead them to wish to end their 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 Margo MacDonald quite rightly puts 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 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 end in life in the sense of an ‘emergency exit’, can lift the feeling of ‘losing control’; this is what members of DIGNITAS tell us

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<sup>29</sup> 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.

<sup>30</sup> Such as for example the well-known British conductor Sir Edward Downes

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 8<sup>th</sup>, 2007, stating that the result of such media coverage lies much further within the field of fiction than fact.

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

As Margo MacDonald quite rightly states, 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 "enabling, not compelling".

## **6) Comments on the 10 specific questions raised in the consultation document on the proposed Assisted Suicide (Scotland) Bill.**

*Q1. Do you support the general aim of the proposed Bill? Please indicate "yes/no/undecided" and explain the reasons for your response.*

As we can see, the Assisted Suicide (Scotland) Bill has four aims, 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 straightforward process for a qualifying person to follow, involving initial registration followed by two formal requests.
- 3) It will decriminalise the actions of those who assist a qualifying person to end their own life within the parameters set by the Bill.
- 4) It will require a trained and “licensed facilitator” to be present when a qualifying person takes their own life

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 this aim 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 ‘only’ 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. Aims 3) and 4) of the proposed Assisted Suicide (Scotland) Bill adhere to safety and quality requirements and DIGNITAS supports them.

*Q2. What do you see as the main practical advantages of the legislation proposed? What (if any) would be the disadvantages*

The main advantage is clearly that 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) is 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 cannot see any disadvantage from a legislation process which aims at respecting and implementing values of humanity.

*Q3. Do you consider that these suggested eligibility requirements are appropriate? If not, please explain which criterion or criteria you would like to see altered, in what ways, and why.*

As we can see, the consultation document suggests five eligibility requirements, which are that the qualifying person must:

- 1) be capable (i.e. have the mental capacity to make an informed decision – using the definition established by the Adults with Incapacity (Scotland) Act 2000<sup>31</sup>)
- 2) be registered with a medical practice in Scotland
- 3) be aged 16 or over
- 4) have either a terminal illness or a terminal condition
- 5) find their life intolerable

Regarding criterion 1):

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...”<sup>32</sup>. 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 has capacity to consent within the meaning of the law if he or she does not lack the ability to act rationally by virtue of being under age or because of mental illness, mental incapacity, inebriation or similar circumstances”<sup>33</sup>. Any individual – with at least a minimum of physical autonomy – no matter whether mentally competent or not, can

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<sup>31</sup> We presume this to be a typing mistake as we could only find the Adults with Incapacity (Scotland) Act 2000.

<sup>32</sup> See online: <http://www.legislation.gov.uk/asp/2000/4/section/1>

<sup>33</sup> See online: <http://www.admin.ch/ch/e/rs/2/210.en.pdf>

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.

Regarding criterion 2):

We presume that this criterion 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 process of pre-registration in the proposed Assisted Suicide (Scotland) Bill may well take place at a time when an individual is still perfectly healthy. Such an individual may not have a relation with any General Practitioner at all, and those who are healthy would not feel the need to see a doctor. If any pre-registration shall be a criterion, such registration 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).

Regarding criterion 3):

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”<sup>34</sup>. 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.

Regarding criterion 4):

It is generally and widely accepted that individuals suffering from a physical terminal illness such as most forms of cancer, Amyotrophic Lateral Sclerosis (Motor Neurone Disease), Multiple Sclerosis, etc. should be eligible for assistance with a self-determined end in life or even euthanasia. However, there are further ‘categories’ of suffering individuals who would be eligible for assistance (under the “Swiss model”) yet who are not affected by a terminal illness *per se*,

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<sup>34</sup> See online: <http://www.admin.ch/ch/e/rs/2/210.en.pdf>

such as, for example, paraplegics and quadriplegics<sup>35</sup> or patients suffering from Parkinson's, Multiple Systems Atrophy and Huntington's Chorea. Furthermore, 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 Court, in its decision of November 3<sup>rd</sup> 2006<sup>36</sup> 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 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."

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;..."<sup>37</sup>

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

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<sup>35</sup> 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.

<sup>36</sup> BGE 133 I 58, to be found on-line: <http://www.bger.ch/index/jurisdiction/jurisdiction-inherit-template/jurisdiction-recht/jurisdiction-recht-leitentscheide1954.htm>

<sup>37</sup> Case of ARTICO v. Italy (judgment of May 13th, 1980, series A no. 37, no. 6694/74), paragraph 33, to be found online: <http://cmiskp.echr.coe.int/tkp197/view.asp?action=html&documentId=695301&portal=hbkm&source=externalbydocnumber&table=F69A27FD8FB86142BF01C1166DEA398649>

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.

Again, as with criterion 3), DIGNITAS acknowledges that in legislation one has to “draw a line somewhere” in order to establish a legal frame. However, the notion of ‘terminal’ is not appropriate eligibility requirement as it is too narrow and above all discriminating – and thus should be changed.

Regarding criterion 5):

This requirement addresses the aspect of the individual having come to the personal conclusion that his or her life should not continue. Certainly, no-one would seriously consider ending his or her own life if, from his or her personal point of view, this life was not intolerable. The requirement of the individual finding his or her life intolerable makes sure that all action towards an assisted/ accompanied suicide only takes place if the individual in question actually wishes this to happen; said person has to communicate how he or she feels and thus has to express his or her will. For a legal assisted suicide, this is a requirement that can not be done without.

*Q4. What is your general view on the merits of pre-registration (as described above)? Do you have any comments on what pre-registration should consist of, and on whether it should be valid for a set period of time?*

Regarding the pre-registration process as such, we refer to our comment on Question Q3, criterion 2).

*Q5. Do you have any comment on the process proposed for the first and second formal requests (for example in terms of timings and safeguards)?*

First, 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 Roosevelt<sup>38</sup>). “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 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.

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<sup>38</sup> In: The Autobiography of Lincoln Steffens

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 gate-keepers of access to a self-determined end in life.

This last aspect even takes on more weight when it comes down to asking psychiatrists to serve as a part of the ‘gate-keeping’. As mentioned before, the Swiss Federal Court set the prerequisite of a “special in-depth psychiatric opinion”. Yet, it ignored the fact that psychiatrists regularly face an important conflict of interest in such cases: psychiatrists earn their income through the existence of mental disorders in other individuals. Therefore, if psychiatrists are asked to carry out appraisals (which would mean that such a patient could end his or her life), then these psychiatrists, in some health-care systems, from an economic point of view, are compelled to accept a reduction of their income. Amongst medical doctors, psychiatrists (more or less like paediatricians) are the category of medical doctors with the smallest income, and the economic conflict of interest is obvious. In addition, there is a psychological conflict of interest: from the statistics on causes of deaths it can clearly be seen that medical doctors have the highest rate of suicide amongst all occupational groups. Amongst the medical doctors, psychiatrists have an even higher rate of suicide than their colleagues not specialising in psychiatry, with women being at a higher risk than man<sup>39</sup>, and the suicide of patients is traumatic for psychiatrists<sup>40</sup>. Therefore, and for this very reason, a psychological conflict of interest arises for medical doctors and above all psychiatrists: if he or she helps a patient to realise his or her wish for a self-determined end to life by establishing an in-depth appraisal, then he or she further reduces the already low barrier against his or her personal suicidal tendencies by which he or she sees his or her existence endangered. This is known in analytic psychology as transference and countertransference.

The Swiss scientist FRANK TH. PETERMANN showed in his publication “Capacity to Consent (Urteilsfähigkeit)”<sup>41</sup>, the numerous problems which derive from intending to make medical doctors and psychiatrists 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

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<sup>39</sup> Several studies, for example ‘suicide by medical professionals’ (Suizidalität bei Medizinerinnen und Medizinern), see online: [http://www.thieme.de/viamedici/medizin/aerztliches\\_handeln/suizid\\_arzt.html](http://www.thieme.de/viamedici/medizin/aerztliches_handeln/suizid_arzt.html)

<sup>40</sup> See the survey on Scottish consultants, to be found online: <http://bjp.rcpsych.org/content/178/6/494>

<sup>41</sup> FRANK TH. PETERMANN, capacity to consent (Urteilsfähigkeit), pages 81 – 85, cipher 228-234

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.

Now let us turn to the proposed Assisted Suicide (Scotland) Bill, and the ways in which it differs from the “Swiss model”:

The proposed system of a first and then a second formal 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 request<sup>42</sup> 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 medical doctors, that is, one who acknowledges the request and then this medical doctor finding a colleague who would additionally accept 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 requests for personal reasons – which it is their right to do – then getting the first formal request acknowledged becomes almost or entirely a “mission impossible”, especially in the light of having to find a second medical doctor also 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 that the one medical doctor is free to choose contacting a colleague in order to obtain a second opinion.

The proposal of using the time during the formal request(s) 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 is very good liberal approach. 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 medical doc-

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<sup>42</sup> 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>

tor, 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 see again and again that patients are not being sufficiently informed by their medical doctors. A large part of DIGNITAS' counselling work is telling inquirers about patient's rights, about palliative care options 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.

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 acknowledge quicker whilst more complicated 'cases' would take more time to assess.

Asking the qualifying person to sign a form that they consent to the filming of their death is an appropriate measure. At an accompanied suicide with DIGNITAS, if the patient gives consent, the sequence of the patient drinking the barbiturate is filmed, in order to provide one of several proofs to the authorities investigating the proceedings that everything took place within the frame of the law. Within the "Swiss model", there is no legal obligation to provide such proof; however, the good relationship between DIGNITAS and the authorities also involves helping them with their duties.

*Q6. Do you think a time-limit of 28 days (or some other period) is an appropriate safeguard against any deterioration of capacity?*

DIGNITAS feels that implementing an upper limit of a 28<sup>th</sup> day, after which the person would have to begin the formal request procedure from the start again is not appropriate at all, because to set such a limit could 'tempt' the person to go ahead with the assisted suicide knowing that otherwise he or she would lose access to the 'emergency exit' and have to start (and wait) again. In the "Swiss model", there is basically no such 'time window'; once the 'provisional green light' is given, the person is free to request the consultation with the medical

doctor and the assisted/accompanied suicide right away or weeks or months later. The feeling of having a 'provisional green light', this 'emergency exit', is actually what suffering individuals are looking for and – as already outlined earlier in this submission, it is only few, some 14 %, who actually make use of it. There should be no expiry date to this relief element.

Regarding the aspect of deterioration of the capacity (of discernment), which is, as we understand it, the reason why the limit of 28 days became part of the proposal, DIGNITAS suggests changing the aspect of assessing the capacity of discernment in order to do away with the limit, for the reason mentioned before. The "DIGNITAS / Swiss model" may serve as an example:

DIGNITAS follows a step-by-step procedure. The basis is always direct contact between the person requesting an assisted suicide and DIGNITAS. At all times, the initiative and self-determination of the individual is the "graduato": the individual needs to take initiative again and again in order to proceed towards an assisted suicide. If any suspicion arises that the person does not have the capacity to consent or if there is any suspicion of influence on the individual by third parties, there will automatically be an interruption of the proceedings and discussion of the situation. There are several safeguards involved in the proceedings:

- 1) the individual will be in contact with several different members of the staff working in the office of DIGNITAS
- 2) members are visited at home for a preliminary in-depth discussion. Members living far away are visited if it is possible to do so, in certain cases by colleagues of other associations and medical doctors cooperating with these organisation
- 3) one or several medical doctors (who are independent of DIGNITAS) assess the request and at least one personal consultation takes place between the member and the doctor granting the 'green light' for an assisted suicide. The medical doctor assessing the request is free to ask the DIGNITAS-member to come to his office for an additional preliminary consultation before giving the so-called 'provisional green light'
- 4) there are at least two DIGNITAS-companions (the consultation document calls the one person proposed to be present a 'facilitator') present at the assisted/accompanied suicide who are trained to assess the members decision and free will and to look for possible influence by third parties
- 5) relatives and friends of the individual are motivated and welcome to participate in the preparation proceedings and to be present during the assisted suicide: this also allows the DIGNITAS-companions to monitor the interaction between the individual and his or her loved ones.

Everyone involved in counselling and discussing with the member, assessing the request, etc. is trained to monitor the proceedings for possible inconsistencies /

hints such as inconsistent wording (in writing and orally), reluctance to comply with the prerequisites, etc.

In conclusion: with the "Swiss model", the capacity of discernment is not only checked at one specific point in time but in fact all along during the proceedings from a first contact until the actual assisted/accompanied suicide.

DIGNITAS feels that such an approach is a better safeguard to monitor a possible deterioration of capacity of discernment than a one-point-in-time assessment of such capacity and this would allow avoiding the negative aspect of an "upper time limit" as outlined before.

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' 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 medical doctors 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 medical doctors 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 medical doctors 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.

*Q7. Do you agree that the presence of a disinterested, trained facilitator should be required at the time the medication is taken? Do you have any comments on the system outlined for training and licensing facilitators?*

The proposed presence of a trained and licensed 'facilitator' (at DIGNITAS we speak of 'befriender' 'companion' or 'escort'), the role outlined in the consultation paper, 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 with their dire consequences. DIGNITAS supports the proposed presence of a professionally trained facilitator as the advantages are manifold:

- 1) there is a chain of custody for the lethal drug, ensuring that this drug reaches only the qualifying person and – if not used – is returned to the pharmacy
- 2) it is a safety measure as the trained facilitator would instruct the qualifying person on how to take the drug, thus avoiding a failed suicide
- 3) the facilitator could check on the capacity of discernment of the qualifying person just like the medical doctor before him or her and look into the stability of the wish to die
- 4) the assisted suicide is documented, profoundly facilitating the work of the authorities, especially the coroner and the police who would otherwise – with a not-yet-determined cause of death – have to start a time-consuming (and costly) investigation
- 5) as a professional facilitator would certainly be expected to be also a compassionate, empathetic character, he or she would attend to the emotional needs of the qualifying person and even more so to the loved ones present in the last hour.

As a point of difference to the proposal, 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 qualifying 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. Furthermore, if any filmed record would be established, especially of the last act of the person drinking the lethal drug, it is most helpful to have the second facilitator available to handle the camera. Having two facilitators present is a safety and quality control measure in the sense that “four eyes are better than two”.

Regarding the system outlined for training and licensing facilitators, DIGNITAS feels that the proposal has a sensible approach on vetting and licensing: however, there are not yet sufficient details stated in the consultation paper which would allow us to comment on this in depth. One aspect which is not mentioned but which should be included, is the option for facilitators to have (free of charge) access to debriefing / psychological supervision (intravision). At DIGNITAS, everyone, no matter whether they work in the office or act as a befriender, can choose to see a professional (outside, independent of the organisation) for debriefing / supervision and the organisation will pay the expense.

*Q8. What sort of documentation and evidence is likely to be required? In particular, how important is it that the process is filmed?*

At an accompanied suicide with DIGNITAS, there are several documents in use which all need to be present, signed, before the lethal drug can be handed over to

the person wishing to end his or her life:

- 1) The DIGNITAS Living Will; everyone signing up as a member of DIGNITAS automatically receives this form (also called 'Patient's Instructions' or 'Advance Directive') to fill out.
- 2) A copy of the formal request for an accompanied suicide which earlier on led to a 'provisional green light' by a Swiss medical doctor
- 3) A 'Voluntary Death Declaration'; a form through which the patient confirms that he or she, after careful reflection, has decided to exercise his or her right to terminate his or her life in accordance with his or her own free will. At the same time, the document solemnly and unrestrictedly instructs DIGNITAS to safeguard and attend to his or her interests as well as to putting it into effect.
- 4) A Power of Attorney which will allow DIGNITAS to handle all affairs with the Swiss authorities after the death (arrangements with the civil registry office to officially register the death and issue the death certificate, arranging transport of the coffin or the urn to the homeland of the patient, etc.)
- 5) A 'Disposition of personal belongings'; a form by which the patient instructs everyone present at the accompanied suicide what should happen to his or her belongings (for example clothes, jewellery, watch, medication, wallet with contents, etc.) after the death, such as (for example) disposal, destruction, despatch to next of kin / friends, etc.

This list may serve as an example for the Assisted Suicide (Scotland) Bill. All these documents make up a file available to the Swiss authorities (police / coroner) who investigate each case of assisted suicide.

As to the importance of the process being filmed, one should bear in mind that a camera can be felt to be intrusive, even voyeuristic, especially in the circumstances of an event as personal and intimate as an accompanied suicide! There are patients who do not want to be filmed in their deplorable state of health. One must respect their values on personal dignity and therefore filming should be voluntary – never mandatory. DIGNITAS' experience drawn from good cooperation with the Swiss authorities is that having a filmed record (at least of the moment when the patient drinks the drug) can facilitate procedures after an accompanied suicide; in the sense of "a picture says a thousands words". However, the documents listed above as well as the step-by-step procedure towards an assisted/accompanied suicide provide sufficient evidence to document the proceedings and thus filming is not that important.

*Q9. What is your assessment of the likely financial implications of the proposed Bill to your organisation? Do you consider that any other financial implications could arise?*

For DIGNITAS, there will not be any financial implications due to the proposed Bill. DIGNITAS is a charity, a NPO (not-for-profit-organisation); costs are

charged only to cover the expenditures of maintaining the services, including services of suicide attempt prevention for non-members. Fewer people using DIGNITAS' services would lead to fewer payments being received: this keeps the balance with the organisation having less work and thus less expenditure.

As to other financial implications, DIGNITAS adheres to those stated in the consultation paper. Further to these, there might be costs for the Health Care System as medical doctors would assess requests for an assisted suicide.

*Q10. Is the proposed Bill likely to have any substantial positive or negative implications for equality? If it is likely to have a substantial negative implication, how might this be minimised or avoided?*

As already pointed out in our comment on Question 3, criterion 4, 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 such as train drivers, rescuers, etc. The proposed Assisted Suicide (Scotland) Bill sets an eligibility criterion on the person to "have either a terminal illness or a terminal condition". However, from both a humanitarian and human rights approach, limiting access to the group of the terminally ill is discrimination and is not justifiable. DIGNITAS strongly recommends that the limiting notion of 'terminal' is done away with.

In this context, definitions are important but at the same time problematic as especially in end-of-life issues, one must avoid lumping together that which needs to be distinguished: what is the meaning of 'terminal'? What is a 'terminal condition'? There is no such thing as "the one typical terminally ill patient" and there is no "typical suffering which would make the individual eligible for a certain end-of-life care". Human beings are individuals. Every suffering person experiences his or her situation differently. Physical and mental pain is subjective; it can be judged only to a minor degree by third parties. A humanitarian approach demands that the individual is seen as such, not just as "one patient amongst many others".

At this point, we add an extract<sup>43</sup> of the philosophical and political principles guiding the activities of DIGNITAS which we feel may well serve as a basis for any consideration of end-of-life-issues:

The fundamental values of DIGNITAS are based on values that the Swiss state has upheld since the founding, in 1848, of the modern federation, and the further development of these values on a national and international level since then.

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<sup>43</sup> From the booklet/brochure „How DIGNITAS works“, available online: <http://www.dignitas.ch/images/stories/pdf/so-funktioniert-dignitas-e.pdf>

The starting point is the liberal position that in a free state any freedom is available to a private individual provided that the availing of that freedom in no way harms public interests or the legitimate interests of a third party. As John Stuart Mill stated:

“Over himself, over his own body and mind, the individual is a sovereign.”<sup>44</sup>

These values are:

- Respect for the freedom and autonomy of the individual as an enlightened citizen
- Defending this freedom and autonomy against third parties who try to restrict those rights for some reason, whether ideological, religious or political
- Humanity which seeks to prevent or alleviate inhumane suffering when possible: probably the most shining example of this in our history, on a national and international level, led to the founding of the Red Cross
- Solidarity with weaker individuals, in particular in the struggle against conflicting material interests of third parties
- Defending pluralism as a guarantee for the continuous development of society, based on the free competition of ideas
- Upholding the principle of democracy, in conjunction with the guarantee of the constant development of fundamental rights

Respect for the freedom of individuals:

Respect for the freedom of individuals in the form of an enlightened citizen who takes on personal responsibility (a “citoyen” in the sense of the political philosopher from Basel, ARNOLD KÜNZLI, who died in 2008<sup>45</sup>); he also reveals, among other things, that – in contrast to earlier law – constructive law valid today no longer punishes a suicide attempt.

Freedom from the expectations of a third party:

It is also clear that every person on Swiss soil is entitled to the freedom to live his or her life independent of the individual ideological, religious or other types of ideas of a third party.

No one has the right to impose or even attempt to impose his or her individual ideological, religious or political beliefs on another. Muslims should not do it to Christians, Jews or Buddhists. Christians should not do it to Jews or those of other beliefs and a believer should not do it to an unbeliever – not even using the indirect method of a governmental regulation.

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<sup>44</sup> JOHN STUART MILL, *Essay on Liberty*, Library of Liberal Arts edition, p. 13.

<sup>45</sup> As described in his essay „Bourgeois und Citoyen: Das Doppelgesicht unserer Gesellschaft“, in: Michael Haller, Max Jäggi, Roger Müller (Ed.), *Eine deformierte Gesellschaft, Die Schweizer und ihre Massenmedien*, Basel 1981, p. 299 ff.)

In this case, the state should be the guarantor of a pluralistic society and must forbid anything that would restrict this pluralism or lead it in a certain direction in the interest of a specific ideological viewpoint.

Humanity:

When addressing the question of whether a person who wishes to die should be offered help, humanity needs to be the central focus.

The term "humanity" is admittedly vague in and of itself; however, it plays an important role for example in the "Declaration of Geneva", which was adopted by the General Assembly of the World Medical Association in 1948 and last amended in 2006.

Although this declaration does not make any reference to medically assisted suicide, it does begin with the formulation:

"I solemnly pledge to consecrate my life to the service of humanity"

The declaration also contains the following as its final sentences:

"I will maintain the utmost respect for human life; I will not use my medical knowledge to violate human rights and civil liberties, even under threat".

Since experience shows, however, that it is difficult to interpret the undefined terms of humanity, respect or even dignity as such, in the end the only help comes from the decision to stop and consider what is the true objective of medicine instead of relying on interpretation.

The German medical ethicist EDGAR DAHL from the Giessen Clinic formulates it this way<sup>46</sup>:

"Medicine consists first and foremost of prevention, diagnosis and therapy. This means that it strives to avoid disease, identify disease and treat disease. One could conclude from this that the objective of medicine is to maintain the health of the individual. In fact, the Declaration of Geneva states that "The health of my patient will be my first consideration". As enlightening as this declaration appears to be, it is however incomplete. A look at palliative medicine is sufficient to show that a doctor's duty is not at all limited to simply maintaining health. For example, palliative doctors spend their days and nights caring for patients whose health cannot be restored.

Based on this, it would seem more suitable to consider the objective of medicine to be the alleviation of human suffering. Looking at it this way, we would also be encouraged by asking ourselves why medicine is committed to avoiding, identifying, and treating disease. The fight against disease is

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<sup>46</sup> In his essay „Im Schatten des Hippokrates / Assistierter Suizid und ärztliches Ethos müssen sich nicht widersprechen“, published in „Humanes Leben – Humanes Sterben“, 4/2008, p. 66-67, Augsburg, Germany.

not an objective in itself. Rather, this fight is taken up to protect us from physical and emotional suffering, which tends to accompany illnesses.

By fulfilling its objective to alleviate human suffering, medicine is however continually bound to respecting the self-determination of human beings. No one is allowed to treat a patient against his or her will. That doctors are only permitted to introduce or terminate medical procedures with the express permission of the patient is now a generally accepted fact. For example, whether or not a life-prolonging procedure is introduced or terminated is always and exclusively dependent on the agreement of the patient involved.

When medical ethics, as described above, are based on the alleviation of suffering and the respect of self-determination, it should be obvious that these ethics are completely compatible with assisted suicide, since a doctor who fulfils the request of a terminally-ill patient to stop all further therapy and prescribe a lethal medication is alleviating suffering and respecting self-determination."

A policy that is aimed at doing everything possible to prevent every suicide without taking into account the will of the person concerned violates humanity. Whoever acts in this way, forcing people to attempt to bring about their own death in a violent manner, and thus accept the possibility of inhumane risks, is acting inhumanely.

Is it somehow humane to allow a person to achieve his or her own will by attempting something, such as that reported by an interested person from Scotland who e-mailed DIGNITAS in 2008, and to accept the consequences thereof?

"Dear Dignitas. My name is J.(xx) H.(xx). I am 19 years old, and live in Scotland, UK.

About 2 months ago I attempted to commit suicide by jumping off a multi storey car park. My attempt failed, and instead of dying, I write this e-mail to you from my hospital bed.

I crushed both of my feet, broke my leg, broke my knee, broke my sacrum (part of my pelvis) and most devastatingly, broke my spine, in 3 places, which has resulted in a degree of paralysis in my legs. I spent 6 weeks in hospital in my home town of Edinburgh, and was then transferred to a special spinal rehabilitation hospital in Glasgow.

I am told that I will need to spend 6 months at this hospital, and that I will be in a wheelchair for the rest of my life. I now have a loss of sexual function, which seems unlikely to return, as well as huge problems managing my bowels and bladder (I cannot feel them moving).

I was already suicidal, and now that I will be disabled for the rest of my life, at such a young age, I truly cannot bear the prospect of life. I am only 19, and I now have the grim reality of 60 years in a wheelchair. The physical pain

I am in alternates between bearable and completely unbearable. Perhaps the pain will ease off with time, but this is not a certainty. There are times every day where I scream with pain, due to being moved in bed, hoisted into the wheelchair etc.

I would like to ask if I could be considered for an assisted suicide, as I am completely certain I would like to end my life, and believe I should have the right to do so.

I would be too afraid to try and kill myself again, given the devastating effects of my first failed attempt. It would also be much more difficult to attempt suicide from a wheelchair. I only wish that my country was humane enough to let a person die.

Please consider my letter, I hope to hear a response,  
J(xx) H.(xx)"

In this message, which must horrify every person who has any feelings whatsoever, the author has not yet shared what the problem was that motivated him to attempt suicide in the first place.

However, one thing is certain: If, after becoming suicidal, he had had the opportunity to talk with other people about his problem without having to fear that he would be immediately admitted to a psychiatric ward, his fate would have most certainly been different. People would have tried to show him that there were also solutions other than suicide for his problem in order to give him a real chance to solve the underlying problem without resorting to violence against himself. This way, he would not have had to accept the risks that have now marred him in such a devastating way. Under humane conditions of this kind, he would have certainly had a real chance to overcome his suicidal tendencies.

In this context, it is especially important to ask why it is ethically commendable to put a severely suffering animal to death, but it is impossible to allow a severely suffering human to end his or her own life, without having to accept the inconceivable risks of failure and additional self-mutilation. What abstruse ideas could lead someone to declare that what is humane for a person to do to a suffering animal is unethical if done to a suffering human, especially since an animal *cannot* express itself in human speech, yet a human can clearly state his or her will?

Solidarity for the interests of those who are weaker:

Solidarity with, and protecting the interests of, people who are considered weaker, especially in the struggle against the conflicting – and often financially motivated – interests of third parties, is one of the fundamental qualities of the Swiss public spirit.

The principle "One for all and all for one" is not fully realised in the narrow limitations of that which the state directly encourages as solidarity based on the

laws it creates, but rather it is only fully realised in the broader field of social solidarity in civil society, that is, turning a certain group of people towards another group that is in need of special help.

Plurality:

The defence of a pluralistic system is equally important because it alone guarantees that the free competition of ideas, and thereby the further development of society, remains possible.

Democracy and basic rights:

Further significant fundamentals of our shared existence include the principles of democracy within that sphere which is not left up to the individual's own discretion as a consequence of his or her basic rights.

In this context, it must be said that a representative survey on the topic of assisted suicide found that 75 % of the evangelical population and 72 % of the Roman-Catholic population would claim the possibility of assisted suicide for themselves and thus endorsed it<sup>47</sup>.

Citizens are not the property of the state:

Finally it must also be said that people who inhabit a country should never be degraded by being considered the property of the state. They are the bearers of human dignity, and this is characterised most strongly when a person decides his or her own fate. It is therefore unacceptable for a state or its individual authorities or courts to choose the fate of its citizens.

## **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 respected the will of the people and implemented sensible solutions that allow individuals, who so choose, to have a digni-

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<sup>47</sup> in “Reformiert”, August 29<sup>th</sup>, 2008; GALLUP TELEOMNIBUS survey from 3-12 July 2008 through ISOPUBLIC, Schwerzenbach, online (in German): [http://www.reformiert.info/files\\_reformiert/1492\\_0.pdf](http://www.reformiert.info/files_reformiert/1492_0.pdf)

fied, 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 of Margo MacDonald and hopes that an Assisted Suicide (Scotland) Bill finds a majority of open ears 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 Edinburgh<sup>48</sup>:

„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.“

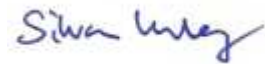
Yours sincerely

**DIGNITAS**

**To live with dignity - To die with dignity**  
Secretary General



Ludwig A. Minelli



Silvan Luley

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<sup>48</sup> DAVID HUME, Of Suicide, <http://ebooks.adelaide.edu.au/h/hume/david/suicide>, in fine