

Suicide Prevention in Scotland: A targeted call for views

Care Not Killing is a UK-based alliance of individuals and organisations which brings together disability and human rights groups, healthcare providers, and faith-based bodies, with the aims of:

- promoting more and better palliative care;
- ensuring that existing laws against euthanasia and assisted suicide are not weakened or repealed;
- influencing the balance of public opinion against any further weakening of the law.

Established in 2006, we have campaigned (successfully) against challenges to the law on assisted suicide and euthanasia in the Houses of Commons and Lords, the Scottish Parliament and in the Courts, most recently in the case of Noel Conway before the Court of Appeal in London, where we intervened formally.

The need constantly to ensure we as a society, and within individual communities, are doing all we can to support those who may feel drawn to suicide as an escape is surely universally recognised, and we applaud this latest effort to address the issue. We wish to restrict our comments to the Committee's first and fourth questions, namely:

- To what extent should the Scottish Government's Suicide Prevention Plan address the issue of inequality?
- Should there be a focus on specific at risk groups and if so what groups would be appropriate?

Advocates of assisted suicide and euthanasia are often keen to stress that what is euphemistically termed 'assisted dying' is a quite separate issue from suicide. Where an Oregon model (based on a six-month life expectancy) is proposed, the claim is made that where people are already close to death, they are not seeking suicide but rather avoiding what they anticipate will be a difficult end. Setting aside serious issues surrounding the accuracy of prognoses and misconceptions concerning the capacity of modern palliative care, such concepts encourage a shift in attitudes.

Some jurisdictions which allow assisted suicide and euthanasia do so on the basis of terminal illness; others disability attended by 'unbearable suffering'; and still others are open to those who are 'tired of life'. Regarding the latter, we have seen just recently the debate sparked by the very public journey of scientist David Goodall from Australia to Switzerland to undergo assisted suicide at the age of 104. He told reporters: 'My abilities have been declining over the past year or two, and my eyesight for the past five or six years, and I no longer want to continue life.'¹ He followed in the (metaphorical) footsteps of 85 year old Italian woman Oriella Caszzenello, who 'chose to end her life because she was "weighed down by ageing and the inevitable loss of the looks of which she was proud."²

We cite these two cases because we believe that the Committee, and the Government, must consider the way in which suicidal ideation among certain groups in society has become normalised by the intense campaign for a change in the law on assisted suicide and euthanasia. In short, people no longer worry so much about certain types of people feeling that they wish to die.

At the time of Lord Falconer's House of Lords Assisted Dying Bill in 2014, Tanni Grey-Thompson, who was born with spina bifida and uses a wheelchair, wrote³ that 'I'm fairly frequently told "It must be horrible being like you". People come up to me and say "I wouldn't want to live if I was like you".' The Baroness is an 11-time Paralympic Gold medallist who has won the London marathon six times, and yet ordinary people look at her life and see no value.

¹ <https://www.independent.co.uk/news/uk/home-news/david-goodall-dead-voluntary-euthanasia-switzerland-clinic-104-british-scientist-latest-a8344706.html>

² <http://www.dailymail.co.uk/news/article-2564023/Italian-woman-85-ends-life-Swiss-Dignitas-clinic-upset-losing-looks.html>

³ <https://www.newstatesman.com/politics/2014/07/tanni-grey-thompson-assisted-dying-people-come-me-and-say-i-wouldn-t-want-live-if-i>

We address your questions concerning inequality and at risk groups together because the mantra of choice, illustrated so vividly by assisted suicide advocates with hard cases, is in our assertion causing people to see certain suicides as more understandable, more justified and ultimately to be offered assistance with. While many people, like Lady Grey-Thompson, have the support and encouragement needed to ward off the impact of such value judgements, we assert that the value society places on the lives of older, sick, disabled and otherwise more vulnerable people is different to those who are physically healthy and younger.

The question of inequality, then, arises particularly where campaigners encourage the public at large to view assisted suicide as an expression of autonomy, without recognising that 'choice' is always limited by other factors, and could be unduly influenced by pressures overt, subtle and perceived. These may include financial considerations and feelings of being a burden.

The World Health Organization, in its guidance to media professionals⁴, recommends the following:

- Don't place stories about suicide prominently and don't unduly repeat such stories
- Don't use language which sensationalizes or normalizes suicide, or presents it as a constructive solution to problems
- Don't explicitly describe the method used
- Don't provide details about the site/location
- Don't use sensational headlines
- Don't use photographs, video footage or social media links

In claiming that 'assisted dying' is distinct from suicide more broadly, campaigners have been able to bring case after case of individuals seeking or undergoing assisted suicide, often with emotive photography and video footage. These are always presented in terms of being cases where the reader or viewer is expected to consider the decision to end life understandable and reasonable, with assistance depicted as honourable and even made too difficult to render. The media and campaigners between them have, we submit, contributed to a narrative of certain suicides being reasonable responses to perceived difficulties on the part of all people in comparable situations.

This might drive support for a change in the law in the long-term, which of course we would not welcome, but right now, in the current legal context, we view as extremely difficult any approach to suicide prevention which treats suicide differently depending on age, disability or illness. Any suicide prevention policy which considers some suicides to be reasonable, and not worth every bit as much effort to dissuade as others, is not fit for purpose. To that end, the Committee should give strong consideration to collaboration with providers of palliative and social care to ensure that inconsistent provision of services does not drive despair: it is a recurring theme in personal stories of difficult deaths that these have been made worse by incidental failures to provide care which our health services are capable of providing and indeed do provide.

We thank the committee for the opportunity to submit comments.

Care Not Killing

18 May 2018

⁴ <http://apps.who.int/iris/bitstream/handle/10665/258814/WHO-MSD-MER-17.5-eng.pdf;jsessionid=BD68FA8E4822E61378E4799EAF4E08FC?sequence=1>