Proposed Assisted Dying for Terminally Ill Adults (Scotland) Bill

Introduction

A proposal for a Bill to enable competent adults who are terminally ill to be provided at their request with assistance to end their life.

The consultation runs from 23 September 2021 to 22 December 2021.

All those wishing to respond to the consultation are strongly encouraged to enter their responses electronically through this survey. This makes collation of responses much simpler and quicker. However, the option also exists of sending in a separate response (in hard copy or by other electronic means such as e-mail), and details of how to do so are included in the member's consultation document.

Questions marked with an asterisk (*) require an answer.

All responses must include a name and contact details. Names will only be published if you give us permission, and contact details are never published – but we may use them to contact you if there is a query about your response. If you do not include a name and/or contact details, we may have to disregard your response.

Please note that you must complete the survey in order for your response to be accepted. If you don't wish to complete the survey in a single session, you can choose "Save and Continue later" at any point. Whilst you have the option to skip particular questions, you must continue to the end of the survey and press "Submit" to have your response fully recorded.

Please ensure you have read the consultation document before responding to any of the questions that follow. In particular, you should read the information contained in the document about how your response will be handled. The consultation document is available here:

Consultation Document

Privacy Notice

I confirm that I have read and understood the Privacy Notice attached to this consultation which explains how my personal data will be used.

On the previous page we asked you if you are UNDER 12 YEARS old, and you responded Yes to this question.

If this is the case, we will have to contact your parent or guardian for consent.

If you are under 12 years of age, please put your contact details into the textbox. This can be your email address or phone number. We will then contact you and your parents to receive consent.

Otherwise please confirm that you are or are not under 12 years old.

No Response

About you

Please choose whether you are responding as an individual or on behalf of an organisation.
Note: If you choose "individual" and consent to have the response published, it will appear under your own name. If you choose "on behalf of an organisation" and consent to have the response published, it will be published under the organisation's name.

on behalf of an organisation

Which of the following best describes you? (If you are a professional or academic, but not in a subject relevant to the consultation, please choose "Member of the public".)

No Response

Please select the category which best describes your organisation

Third sector (charitable, campaigning, social enterprise, voluntary, non-profit)

Please choose one of the following:

I am content for this response to be published and attributed to me or my organisation

Please provide your Full Name or the name of your organisation. (Note: the name will not be published if you have asked for the response to be anonymous or "not for publication". Otherwise this is the name that will be published with your response).

Bishops' Conference of Scotland

Please provide details of a way in which we can contact you if there are queries regarding your response. Email is preferred but you can also provide a postal address or phone number.

We will not publish these details.

Aim and Approach - Note: All answers to the questions in this section may be published (unless your response is "not for publication").

Q1. Which of the following best expresses your view of the proposed Bill?

Fully opposed

Please explain the reasons for your response.
We fully oppose the proposal for the following reasons:

• Assisted suicide attacks human dignity.

Q1. Which of the following best expresses your view of the proposed Bill?

The principle of the inalienable, inviolable dignity of the human person represents the heart and soul of Catholic social thought. The whole of the Catholic Church's social doctrine develops from this principle and affirms the centrality of the human person in every sector and expression of society.
The United Nations' Universal Declaration of Human Rights recognises 'the inherent dignity and the equal and inalienable rights of all members of the human family' as 'the foundation of freedom, justice and peace in the world.' This dignity, it is important to stress, exists irrespective of age, health, and physical or mental ability.

Assisted suicide attacks human dignity and results in human life being increasingly valued on the basis of its efficiency and utility, to the point of considering as 'unworthy lives' those who do not meet this criterion. Implicit in legal assisted suicide is that an individual can lose their value and worth.
What a sick person needs, besides medical care, is love; the human warmth with which sick persons can and ought to be surrounded by all those close to him or her, parents and children, doctors and nurses. A sick person, surrounded by a loving human presence, can overcome many ills and need not succumb to the anguish of loneliness and abandonment to suffering and death. Moreover, being dependent on others does not mean a loss of dignity. We are, in one way or another, dependent on others from the moment we are born, and this dependence can increase in our later years.
The Church learns from the Good Samaritan how to care for the terminally ill, and likewise obeys the commandment linked to the gift of life: respect, defend, love and serve life, every human life.

The state ought to support the provision of care, not deliberate killing, for those at the end of life.

• Despite claims to the contrary, assisted suicide is not a purely autonomous decision.

All essential decisions that we make are made in relation to other people. Our decisions are affected by other people, and they affect other people in a complex web of thoughts, considerations, and judgements. Family, friends, wider society are all relevant factors in a decision relating to assisted suicide. Moreover, assisted suicide always requires the assistance of a doctor.

Autonomy is important but it is not without limits and must always be considered in the context of the common good. Democratic societies have many laws that limit individual autonomy and choice so as to protect the larger community. These include, among many others, limits on excessive driving speeds and the obligation to contribute by way of personal and corporate income taxes. Moreover, why should autonomy be the supreme value? It is one of many values to be considered, including the inviolability of human life. Fundamentally, there can be no autonomy without first recognising the inherent dignity and value of human life. It is only because society believes in the inherent value of human life that it respects autonomy.

Disturbingly, in 2015 it was reported that 1 in 60 deaths by euthanasia in Belgium occurred without the patient's explicit consent. Most of these were the elderly, those with dementia and those in a coma. This shows that autonomy for the most vulnerable is actually reduced rather than enhanced when assisted suicide or euthanasia is available.

To end the life of a sick person who requests assisted suicide is by no means to acknowledge and respect their autonomy, but on the contrary to disavow the value of both their freedom, now under the sway of suffering and illness, and of their life by excluding any further possibility of human relationship or sensing the meaning of their existence.

• Assisted suicide undermines efforts to prevent suicide and sends a message to society that suicide is an appropriate response to physical or mental suffering.

Suicide prevention efforts rightly affirm that everyone's life matters; that every life has value. However, the legalisation of assisted suicide suggests something very different; it says that sometimes suicide is an appropriate response to an individual's circumstances, worries and anxieties, and that the government will facilitate recourse to suicide.

It would be absurd for civil authorities to provide support for suicide prevention strategies and programmes on one hand, and to permit state-assisted suicide on the other; creating a two-tier system dependent on health or disability status.

Evidence from jurisdictions where assisted suicide or euthanasia is legal shows that the suicide rate amongst the general population has increased. In the Netherlands, suicides increased by 40% between

Q1. Which of the following best expresses your view of the proposed Bill?

2007 and 2016. The suicide rate in Oregon increased by 35% between 2001 and 2018 and was 35% higher than the US national average.

• Assisted suicide sends a clear message to frail, elderly and disabled people about the value that society places on them and puts pressure on people to end their lives for fear of being a financial, emotional or care burden on others.

In Oregon, in 2020, 53 per cent of patients listed being a burden as a reason to end their lives (Oregon Death with Dignity Act 2020 Data Summary). This suggests that society is failing those most in need of help and support in our communities, resulting in elderly and vulnerable people feeling immense pressure to end their lives to lessen the impact on family, friends, carers, and even the state. In such situations the option of assisted suicide becomes less about having a 'right' to die and more about feeling the full weight and expectation of a 'duty' to die. When the elderly express concerns about being a burden, the appropriate response is not to suggest that they have a duty to die; rather, it is to commit to meeting their needs and providing the care and compassion to help them live. If Scotland establishes the provision of death on demand and this becomes normal practice, how will that not become a cultural expectation for the elderly, the lonely, and the vulnerable?

Furthermore, one cannot ignore the deeply troubling prevalence of elder abuse in society. It is estimated that such abuse - which may take the form of physical, psychological and emotional, sexual, financial abuse and neglect - is around the 10 per cent mark (Lachs MS & Pillemer KA (2015) Elder Abuse. New England J Med 373 (20): 1947-1956). If an elderly person is being subjected to abuse by those closest to them it would not be surprising if the resultant misery drove them to consider assisted suicide.

• Assisted suicide undermines public trust in doctors, damaging the doctor-patient relationship.

Patients that 'meet' the criteria for assisted suicide will need to have a conversation with their doctor about whether they wish to choose assisted suicide. Dr Theo Boer, Professor of Ethics at the University of Groningen, referred to this as the "distress of the choice." For those near the end of life in a country where assisted suicide or euthanasia is legal there is no escaping this conversation and its accompanying choice. This will be deeply distressing for many and could result in individuals feeling immense external pressure to choose assisted suicide. It is insidiously coercive.

The care of human life to its natural conclusion, is entrusted to society and, in a very special way, to healthcare workers and is realised through programmes of care that can restore, even in illness and suffering, a deep awareness of their existence to every patient. The need for medical care is born in the vulnerability of the human condition in its finitude and limitations. Our vulnerability forms the basis for an ethics of care, especially in the medical field, which is expressed in concern, dedication, shared participation and responsibility towards the women and men entrusted to us for material and spiritual assistance in their hour of need.
The relationship of care discloses the twofold dimension of the principle of justice to promote human life and to avoid harming another. This principle can be found in the golden rule, "Do unto others whatever you would have them do to you."

Care for life is therefore the first responsibility that guides the physician in the encounter with the sick, and it is a responsibility that exists not only when restoration to health is a realistic outcome, but also when a cure is unlikely or impossible.

Every individual who cares for the sick (physician, nurse, relative, volunteer, pastor) has the moral responsibility to apprehend the fundamental and inalienable good that is the human person. They should adhere to the highest standards of self-respect and respect for others by embracing, safeguarding and promoting human life until natural death.

Medicine must accept the limit of death as part of the human condition. The time comes when it is clear that medical interventions cannot alter the course of an illness that is recognised to be terminal. The impossibility of a cure where death is imminent does not entail the cessation of medical and nursing activity. The judgement that an illness is incurable cannot mean that care has come to an end. The objective of assistance must take account the integrity of the person, and thus deploy adequate measures to provide the necessary physical, psychological, social, familial, and religious support to the sick.
The 'option' of assisted suicide completely alters the doctor-patient dynamic and the wider provision of care in a deeply troubling way. In a society where assisted suicide is legal, care for life can no longer be considered an unqualified principle underpinning the provision of healthcare.

Q1. Which of the following best expresses your view of the proposed Bill?

Deliberately bringing about a patient's death would be akin to crossing the Rubicon for a profession entrusted to act in the best interests of the patient and to first do no harm.

• Evidence is growing of the significant pain and indignity caused by assisted suicide.

Proponents of assisted suicide often describe it is a compassionate, painless, dignified death. In the foreword to his proposal, Liam McArthur writes: "I have long believed that the people of Scotland should be able to access safe and compassionate assisted dying if they choose, rather than face the potential of a prolonged and painful death." Yet there is an emerging body of evidence that assisted suicide may be a painful and undignified experience.

In a letter to the Economist on 27th November 2021, Dr Claud Regnard, Consultant in Palliative Medicine; Amy Proffitt, President of the Association for Palliative Medicine; and Rob George, Professor of Palliative Care, stated that there is no useful data on drug safety regarding drugs used for assisted suicide and warned that 'doctors will be expected to prescribe untested drugs'.

These emerging concerns are heightened by the professional opinion of Dr Joel Zivot, associate professor of anaesthiology and surgery who, writing in The Spectator, said: "I am quite certain that assisted suicide is not painless or peaceful or dignified. In fact, in the vast majority of cases, it is a very painful death." Furthermore, Dr Brick Lantz, Oregon Physician and Oregon State Representative for the American Academy of Medical Ethics, said legal safeguards are "not being followed" in Oregon. He cited the frequent problem of drugs not working as intended, with patients often taking days to die from experimental cocktails of drugs, with one man waking from a coma "after multiple days", and, in another case, a nurse putting "a plastic bag over the head of a patient because the patient wouldn't die."

The most recent report on assisted suicide in Oregon indicates that the complication rate for assisted suicide was nearly 7%, and in 2020, three people took six hours or more to die and another took eight hours to die (Oregon Death with Dignity Act 2020 Data Summary).

• Campaigners in favour of assisted suicide often misrepresent 'dignity' and 'compassion'.

Assisted suicide campaigners often talk about assisted suicide allowing for a dignified end. Co-opting the term in this way implies that if you have a terminal illness and want to maintain dignity at the end of life then you will choose assisted suicide. This also implies that illness can be undignified. It is, with respect to the most vulnerable, insidiously coercive. Suffering does not rob a human being of his or her worth or dignity.

The intrinsic value of human life is diminished by the notion of 'dignified death' as measured by the standard of the 'quality of life', which a utilitarian anthropological perspective sees in terms 'primarily related to economic means, to 'well-being' to the beauty and enjoyment of physical life, forgetting the other, more profound, interpersonal, spiritual and religious dimension of existence. In this perspective, life is viewed as worthwhile only if it has, in the judgement of the individual or of third parties, an acceptable degree of quality as measured by the possession or lack of particular psychological or physical functions, or sometimes simply by the presence of psychological discomfort. According to this view, a life whose quality seems poor does not deserve to continue. Human life is thus no longer recognised as a value in itself.

Further, proponents of assisted suicide peddle a false understanding of 'compassion'. In the face of seemingly 'unbearable' suffering, the termination of a patient's life is justified in the name of 'compassion'. This so-called 'compassionate' assisted suicide or euthanasia holds that it is better to die than to suffer. In reality, human compassion consists not in causing death, but in embracing the sick, in supporting them in their difficulties, in offering them affection, attention, and the means to alleviate their suffering.

• Assisted suicide undermines efforts to improve palliative care. – see answer to Question 2.

Q2. Do you think legislation is required, or are there other ways in which the Bill's aims could be achieved more effectively? Please explain the reasons for your response.

Legislation is not required given the reasons set out in answer to Q1.

Legalising assisted suicide risks compromising the provision of palliative care services in Scotland. In a letter to the Economist on 27th November 2021, Dr Claud Regnard, Consultant in Palliative Medicine; Amy Proffitt, President of the Association for Palliative Medicine; and Rob George, Professor of Palliative Care, stated that 'palliative care does not flourish with assisted dying', highlighting that the Belgian and Dutch 'growth in all palliative care services has stalled since 2012.'

Furthermore, in Canada, funding to several hospices has been withdrawn because they refused to participate in assisted deaths. And in Oregon, in 2012, two thirds of hospice programmes did not take part in assisted deaths. Dr Claud Regnard said that these statistics highlight a developing 'tension' between 'hospices providing death and those caring for the dying.'

Energies and resources should focus on improvements to palliative care so that an excellent standard of care is available to all. A properly resourced, holistic approach to palliative care that is consistently available across the whole country, including at home, must be a priority. This approach would include palliative care teams of doctors, nurses, physiotherapists, occupational therapists, pharmacists, chaplains, social workers, and volunteers; all with the aim of relieving and minimising the physical, psychosocial and spiritual suffering of patients and those who care for them.

Palliative medicine constitutes a precious and crucial instrument in the care of patients during the most painful, agonising, chronic and terminal stages of illness. Palliative care is an authentic expression of the human activity of providing care, the tangible symbol of the compassionate remaining at the side of the suffering person. Its goal is to alleviate suffering in the final stages of illness and at the same time to ensure the patient appropriate human accompaniment improving quality of life and overall wellbeing as much as possible and in a dignified manner.

It is essential that the sick do not feel themselves to be a burden but can sense the intimacy and support of loved ones. The family needs help and adequate resources to fulfil this mission. Recognising the family's primary, fundamental and irreplaceable social function, governments should undertake to provide the necessary resources and structures to support it.

Next to the family, hospices which welcome the terminally sick and ensure their care until the last moment of life provide an important and valuable service. These centres are an example of genuine humanity in society, sanctuaries where suffering is full of meaning. For this reason, they must be staffed by qualified personnel, possess the proper resources, and always be open to families.

The proposal to legalise assisted suicide, to be blunt, provides a quick, cheap alternative to good palliative care. Mr McArthur's proposal chillingly concedes that it is cheaper to end life than to provide care (see footnote 124, page 28 of the consultation document).

The focus must be providing care, not providing a cheap death.

Q3. Which of the following best expresses your view of the proposed process for assisted dying as set out at section 3.1 in the consultation document (Step 1 - Declaration, Step 2 - Reflection period, Step 3 - Prescribing/delivering)?

Fully opposed

Please explain the reasons for your response, including if you think there should be any additional measures, or if any of the existing proposed measures should be removed. In particular, we are keen to hear views on Step 2 - Reflection period, and the length of time that is most appropriate.
There is a significant risk that legalising assisted suicide would give too much power to doctors, effectively making them arbiters of life and death. Furthermore, assisted suicide will bring about a monumental shift in the doctor-patient dynamic. For those deemed 'eligible' to request assisted suicide this will need to be discussed between the doctor and patient. How will this make the patient feel? Will they see it as a suggestive nod towards assisted suicide? Will it tip an already vulnerable individual over the edge?

The proposal worryingly refers only to consideration of 'feasible' alternatives to assisted suicide in

Q3. Which of the following best expresses your view of the proposed process for assisted dying as set out at section 3.1 in the consultation document (Step 1 - Declaration, Step 2 - Reflection period, Step 3 - Prescribing/delivering)?

discussions between the doctor and patient. This is dangerously subjective. If assisted suicide was to be legalised, all alternatives to assisted suicide must be discussed with a patient and, further, appropriately qualified professionals should be responsible for providing information, for example, palliative care doctors should be brought in to discuss palliative care options. Perhaps most concerning is that Mr McArthur neglects to include a mandatory psychiatric or psychological assessment of the patient in his proposal.

Rather than increasing options at the end of life as proponents would wish us to believe, these proposals actually appear to limit people's options when they are at their most vulnerable. For example, in Canada, less than half of patients who participate in assisted suicide or euthanasia see a specialist palliative care team, and only 15 per cent of Canadians have access to publicly funded palliative care at home (Munro C, Romanova A, Webber C, Kekewich M, Rayelle R, Tanusepurto P. Involvement of palliative care in patients requesting medical assistance in dying. Canadian Family Physician, 220; 66: 833-42 and Access to Palliative Care in Canada. Ottowa: Canadian Institute for Health Information, 2018, p6).

Finally, there is no detail on the 'life-ending medication' referred to in the proposal. What does it consist of? How 'effective' is it? What is the 'failure' rate? What happens if the procedure does not go as planned? As referenced in our response to question 1, the most recent report on assisted suicide in Oregon indicates that the complication rate for assisted suicide was nearly 7%, and in 2020, three people took six hours or more to die, and one other took eight hours to die (Oregon Death with Dignity Act 2020 Data Summary).

Q4. Which of the following best expresses your views of the safeguards proposed in section 1.1 of the consultation document?

Fully opposed

Please explain the reasons for your response.
The McArthur proposal surprisingly neglects to include a mandatory psychiatric or psychological assessment of the patient. Furthermore, and irrespective of one's view on the principle of assisted suicide, the fourteen-day waiting period of reflection is woefully short for a decision of this magnitude.

No matter how well intentioned the safeguards are, it is impossible for any government to draft assisted suicide laws which include legal protection from future expansion of those laws. The slippery slope is real and dangerous. For example:

• Canada has eroded safeguards in just five years: expanding from terminal illness to include chronic illness and disability; removing the ten-day period for reflection; and waiving the requirement for final consent. From 2023, patients who suffer from mental health problems will have the right to request a medically assisted death.

• In Oregon, terminal illness includes illness resulting from a refusal of treatment for chronic, treatable conditions, such as insulin-dependent diabetics.

• In the Netherlands, in 30 years, the country has moved from euthanasia of people who are terminally ill to euthanasia of those who are chronically ill; from physical illness to mental illness; from mental illness to psychological distress or mental suffering; and now to euthanasia for those who are over the age of 70 and are simply tired of life. Moreover, cases in the Netherlands include suffering from an accumulation of old-age disorders, for example, sight and hearing disorders, osteoperosis, osteoarthritis, and cognitive decline. The move to include mental illness is deeply concerning as it is 'not possible for doctors to accurately determine medical futility; that is, to decide that a given psychiatric condition is irremediable, and that there is therefore no prospect of recovery or therapeutic improvement of any kind'. Therefore, 'it is essentially impossible to describe any psychiatric illness as incurable.' (Euthanasia and Assisted Suicide – When Choice is an Illusion and Informed Consent Fails, Dr Gregory K Pike).

• In Belgium, in 2014, the law was extended to include terminally ill children of any age, entailing a shift from voluntary to non-voluntary killing – as it is not possible for a baby to give consent. Furthermore, in Belgium, 10 per cent of children who die before their first birthday die as a result of a euthanasia procedure (Dombrecht L, Beernaert K, Chambaere K, et al, End-of-life decisions in neonates and infants: a

Q4. Which of the following best expresses your views of the safeguards proposed in section 1.1 of the consultation document?

population-level mortality follow-back study Archives Disease in Childhood – Fetal and Neonatal Edition: 15 June 2021).

Q5. Which of the following best expresses your view of a body being responsible for reporting and collecting data?

Fully opposed

Please explain the reasons for your response, including whether you think this should be a new or existing body (and if so, which body) and what data you think should be collected.
Such a body would not be required if the proposals were abandoned.

Q6. Please provide comment on how a conscientious objection (or other avenue to ensure voluntary participation by healthcare professionals) might best be facilitated.

Conscientious objection would be difficult to maintain as it may be eroded over time, particularly through court actions, as we have seen in other areas of medical practice.

Governments must acknowledge the right to conscientious objection in the medical and healthcare field, where the principles of the natural moral law are involved and especially where in the service to life the voice of conscience is daily invoked.

The right to conscientious objection does not mean that Christians, for example, reject these laws in virtue of private religious conviction, but by reason of an inalienable right essential to the common good of the whole society. They are in fact laws contrary to natural law because they undermine the very foundations of human dignity and human coexistence rooted in justice.

Financial Implications

Q7. Taking into account all those likely to be affected (including public sector bodies, businesses and individuals etc), is the proposed Bill likely to lead to:

a significant reduction in costs

Please indicate where you would expect the impact identified to fall (including public sector bodies, businesses and individuals etc). You may also wish to suggest ways in which the aims of the Bill could be delivered more cost-effectively.
The proposal chillingly concedes (footnote 124 on page 28) that it is cheaper to end life than to provide care. This reduces the individual to a mere commodity whose value is his or her economic contribution to society. The social narrative created by this utilitarian view will put pressure on some of the most vulnerable people in our communities, pushing them towards assisted suicide.

Equalities

Q8. What overall impact is the proposed Bill likely to have on equality, taking account of the following protected characteristics (under the Equality Act 2010): age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation?

Negative

Please explain the reasons for your response. Where any negative impacts are identified, you may also wish to suggest ways in which these could be minimised or avoided.
Assisted suicide undermines the inherent value of human life. As set out in our response to Question 1, assisted suicide results in human life being increasingly valued on the basis of its efficiency and utility, to the point of considering as 'unworthy lives' those who do not meet this criterion. Implicit in legal assisted suicide is that an individual can lose their value and worth. Mr McArthur's proposals would have a profoundly negative effect on the elderly and disabled, rendering lives less valuable and less worthy, and deepening inequalities.

Sustainability

Q9. In terms of assessing the proposed Bill's potential impact on sustainable development, you may wish to consider how it relates to the following principles:

• living within environmental limits
• ensuring a strong, healthy and just society
• achieving a sustainable economy
• promoting effective, participative systems of governance
• ensuring policy is developed on the basis of strong scientific evidence.

With these principles in mind, do you consider that the Bill can be delivered sustainably?

No

General

Q10. Do you have any other additional comments or suggestions on the proposed Bill (which have not already been covered in any of your responses to earlier questions)?

It is important to be clear about terms in a proposal for legislation. Mr McArthur's proposal erroneously refers to 'assisted dying'. Deliberately ending one's own life is commonly accepted as suicide. Therefore, assisting someone to end their own life (as per the proposal) is 'assisted suicide', not 'assisted dying' as is posited. Furthermore, the proposal erroneously describes assisted suicide as a medical procedure. It is not. It is the prescribing of lethal drugs to a patient to bring about the patient's death.

It is worth noting that a majority of end-of-life care medical professionals have expressed opposition to assisted suicide. Eight-two per cent of members of the Association for Palliative Medicine of Great Britain & Ireland rejected the legalisation of assisted suicide when last polled in 2015 (Association of Palliative Medicine of Great Britain and Ireland (APM) survey on Assisted Suicide). Furthermore, Fifty-four per cent of British Medical Association members responding to a 2020 survey said that they would not be willing to actively participate in the process of administering life-ending drugs, should it be legalised.

Finally, given that the consequences of the decision to request assisted suicide are deadly and irreparable it is clear that a law legalising assisted suicide is extremely high risk. MSPs, who will ultimately be responsible for introducing such a law, ought to think very carefully about the significance and consequences of their decision; a decision which will have far-reaching consequences, especially for the sick, the disabled, the elderly, the lonely and the most vulnerable.