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

Representative organisation (trade union, professional association)

Optional: You may wish to explain briefly what the organisation does, its experience and expertise in the subject-matter of the consultation, and how the view expressed in the response was arrived at (e.g. whether it is the view of particular office-holders or has been approved by the membership as a whole).
British Islamic Medical Association (BIMA) is a national, democratic organisation that aims to unite, inspire and serve Muslim healthcare professionals in the UK, seeking to improve healthcare for all.

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).

British Islamic Medical Association

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 at the British Islamic Medical Association (BIMA) recognise there are challenging dilemmas facing patients, their families, and their physicians at the end of life. However, we are opposed to the concept of assisted suicide and concerned about the many implications that this will have on doctors, their patients, and a relationship that has always been predicated on "first do no harm."

As Muslims, we inherently believe in the sanctity of life; indeed it is the foremost maxim out of the five leading objectives of Islamic Law – meaning that all laws will be designed around the protection of human life. Even in the most difficult of circumstances, we feel that the focus should be on better pain relief, communities coming together and supporting the sick, investing in research for cures, and supporting our world-leading palliative care services. As God says in the Quran: "Do not kill yourselves, for verily God has been to you most merciful" (Quran 4:29). The opposition to assisted suicide is a position that has unanimous consensus from Islamic scholars and jurists across the globe.

Any shift away from the current stance of professional opposition to assisted suicide may have far-reaching consequences for patients and healthcare professionals, especially those who are opposed to it on the grounds of their faith or conscience. Questions remain as to what neutrality actually means in practice, and how patient trust in physicians who may 'treat' them with death will be maintained. In an increasingly austere environment, we are concerned that the narrative will paint those who are made vulnerable by ill health as burdens on their families and taxpayers, pressurising them to take this route.
unanimous consensus from Islamic scholars and jurists across the globe.

Society should not allow a double standard in seeking to allow some people assistance in suicide, as we do all we can to prevent young people and other vulnerable groups from committing suicide. The 'right to die' can easily become the 'duty to die' as the suicides of the elderly and infirm become normalised. Dutch ethicist Professor Theo Boer (a former proponent of assisted suicide who changed his position after reviewing thousands of cases of euthanasia) has noted (https://www.dailymail.co.uk/news/article-2686711/Dont-make-mistake-As-assisted-suicide-bill-goes-Lords-Dutch-regulator-backed-euthanasia-warns-Britain-leads-mass-killing.html): "'Pressure from relatives, in combination with a patient's concern for their wellbeing, is in some cases an important factor behind a euthanasia request. Not even the review committees, despite hard and conscientious work, have been able to halt these developments.'"

Licensing doctors to provide lethal drugs to patients is fundamentally different from withdrawing ineffective life-sustaining treatment, and crosses a Rubicon in medicine. The role of doctors is to support patients to live as well, and as comfortably, as possible until they die, not to deliberately bring about their deaths. The possibility of misdiagnosis and non-medical pressures on a patient to end their own lives demonstrates the difficult position such legislation would place doctors in.

Other nations demonstrate that once assisted suicide is legalised, a slippery slope begins, and eventually individuals with disabilities, mental illness and other chronic but non -life- threatening diseases, as well as minors, have access to assisted suicide. This is clear in common and civil law jurisdictions. Belgium (https://www.dw.com/en/belgium-approves-assisted-suicide-for-minors/a-17429423) and the Netherlands (https://www.bbc.co.uk/news/world-europe-54538288) have expanded their provision of assisted suicide and euthanasia to include children. Oregon (https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf) has expanded its list of applicable conditions to now include arthritis, complications from a fall, and kidney failure, among other non-terminal conditions.

Assisted suicide is far from a fully autonomous decision. Suffering patients may choose assisted suicide out of a sense of responsibility to their families or communities rather than from a personal desire to die. It is commonsensical that legalising assisted suicide might encourage some patients to imitate the actions of their friends and relatives who undergo the procedure. Autonomy, then, becomes a form of abandonment. The latest reports from American states that have sanctioned assisted suicide demonstrate that vulnerable patients have sought to die for fear of burdening their families. For example, 51% of patients from Washington state in 2018 cited concerns (https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2018.pdf) that they would be a burden on their family, friends, and caregivers should they continue to live. Ultimately, these are existential rather than medically intractable issues.

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.

No, legislation to introduce assisted suicide to Scotland is not required. A better alternative would be to invest in the provision of palliative care services and urgently needed clinical staff, to increase awareness around the current choices around end-of-life care already available in Scotland.

There is no legal prohibition against refusing or discontinuing life-extending treatment. Doctors may treat us only with our consent. Terminally ill patients who wish to let their illness take its course without further treatment have been duly provided for. And, if they do so, their doctors have a duty of care to provide relief of pain or other distress. It is not true that terminally ill people are forced by the law to suffer. What there should never be is the right to be killed. It's the difference between accepting death and seeking death.

The possibility of prosecution for assisted suicide both protects vulnerable people from abuse, such as the elderly, infirm, and those with disabilities. Both euthanasia and assisted suicide are effectively outlawed (https://archive2021.parliament.scot/parliamentarybusiness/report.aspx?r=9717&mode=pdf) in Scotland. Suspected cases of assisted suicide or euthanasia can be treated under homicide law, but the Crown Office and Procurator Fiscal Service has not prosecuted (https://archive2021.parliament.scot/parliamentarybusiness/report.aspx?r=9717&mode=pdf) a case of assisted suicide since 2006.
It is our duty as professionals to speak in the interests of our patients, even if it goes against prevailing and evolving norms. We must continue to safeguard the interests of patients, healthcare professionals and the community as a whole.

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.
No assisted suicide law can ever be a safe law. Evidence from overseas demonstrates that, incrementally but inevitably, the 'right to die' extends from 'hard cases' to a more holistic provision, despite the best intentions of those arguing in favour of regulated mild reform.

The Dutch ethicist and former member of one of the five Regional Review Committees on Euthanasia in the Netherlands between 2005 and 2014 where he reviewed over 4,000 cases, Professor Theo Boer, who formerly supported assisted suicide, pleaded to the UK Parliament not to pass Lord Falconer's assisted suicide bill in July 2014. Dr Boer commented (https://www.dailymail.co.uk/news/article-2686711/Dont-make-mistake-As-assisted-suicide-bill-goes-Lords-Dutch-regulator-backed-euthanasia-warns-Britain-leads-mass-killing.html) that "In 2007 I wrote that 'there doesn't need to be a slippery slope when it comes to euthanasia . . . But we were wrong - terribly wrong . . . Whereas the law sees assisted suicide and euthanasia as an exception, public opinion is shifting towards considering them rights, with corresponding duties on doctors to act." We must avert the legalisation of assisted suicide which will incrementally but inevitably extend from 'hard cases' to a more holistic provision, despite the best intentions of those arguing in favour of regulated mild reform (https://philpapers.org/rec/KEOEEA). Such change would fundamentally alter the relationship between physicians and patients by introducing suicide as an acceptable mode of medicine.

The Dutch ethicist, Professor Theo Boer, summarises the issue well: 'Whereas assisted dying in the beginning was the odd exception, accepted by many —including myself — as a last resort [. . .] [P]ublic opinion has shifted dramatically toward considering assisted dying a patient's right and a physician's duty' (https://adflegal.blob.core.windows.net/international-content/docs/default-source/default-document-library/resources/white-papers/a5-book_euthanasia-ebook-finalc.pdf?sfvrsn=2).

The lack of mandatory psychological assessment as part of the application for assisted suicide in other international jurisdictions, especially the American states, seems to contrast with the understanding that suicidal ideation should be treated as an instance of psychological distress. This may be failing those vulnerable patients who experience fleeting desires to die and require psychological care rather than

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assisted suicide. For instance, only five mental health provider's confirmations were received for a total of 508 cases of assisted suicide over four years under the End of Life Option Act in Colorado, USA (https://drive.google.com/file/d/1zJClMv9bSMIJjrE_YoDhSeSNh98qsnDq/view).

An assisted suicide law, however well-intended, would alter society's attitude towards the disabled, suggesting that assisted suicide is an option they 'ought' to consider. Canada has been criticised (https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=24481&LangID=E) by successive (https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26687) UN special rapporteurs for a "growing trend to enact legislation enabling access to medically assisted dying based largely on having a disability or disabling conditions, including in old age." All major UK disability rights groups oppose assisted suicide (such as Disability Rights UK (https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26687), SCOPE (https://www.scope.org.uk/media/press-releases/scope-concerned-by-reported-relaxation-of-assisted-suicide-guidance/), United Kingdom's Disabled People's Council (https://www.carenotkilling.org.uk/links/the-united-kingdoms-disabled-peoples-council-ukdpc/), and Not Dead Yet UK (http://notdeadyetuk.org/)).

A study of suicide rates in American states that have legalised assisted suicide has illustrated that legalisation is associated with an increase rather than a reduction in the total suicide rate (https://drive.google.com/file/d/1zJClMv9bSMIJjrE_YoDhSeSNh98qsnDq/view).

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.
Society should not allow a double standard in seeking to allow some people assistance in suicide, even as we do all we can to prevent young people and other vulnerable groups from committing suicide.

So-called safeguards cannot provide safety from the dangerous and damaging normalisation of suicide. The existing law focuses on the facts of what has happened in any case of assisted suicide. This is different from the proposed regime, whereby requests for lethal drugs would be assessed by a minority of doctors who are supportive of such practices and who in many cases would never have met the applicant before and would be ill-placed to make the social judgements (e.g. a settled wish to die, freedom from pressure) which form an important part of the assessment process envisaged. The existing law rests on a widely-supported and rational boundary – that we do not as a society aid and abet the suicides of others. Once that natural boundary is weakened by the introduction of arbitrary exceptions – such as terminal illness – it becomes just a line in the sand, easily crossed and hard to defend. Such laws contain within themselves the seeds of their own expansion.

A 2014 article (https://www.wweek.com/portland/article-22574-penalized-by-the-death-penalty.html) raised concerns about the availability of assisted suicide drugs in Oregon as they are also used in executions by lethal injection.

Belgium (https://www.dw.com/en/belgium-approves-assisted-suicide-for-minors/a-17429423) and the Netherlands (https://www.bbc.co.uk/news/world-europe-54538288) have expanded their provision of assisted suicide and euthanasia to include children. The American state of Oregon has expanded its list of applicable conditions to now include arthritis, complications from a fall, and kidney failure, among other non-terminal conditions (https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf).

In Oregon (https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf), often referenced as an exemplary case study of moderate reform, there has been an almost fifteen-fold increase in the number of deaths from lethal prescriptions from its

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inception in 1998 to 2020, including a 28% increase from 2019 to 2020 alone. In Switzerland, figures (https://www.bfs.admin.ch/bfs/de/home/aktuell/neue-veroeffentlichungen.assetdetail.11348852.html) from December 2020 (https://www.bfs.admin.ch/bfs/de/home/aktuell/neue-veroeffentlichungen.assetdetail.14966044.html) show the number of assisted suicides continues to increase annually, from 187 cases in 2003 to 1176 cases in 2018. This represents around a 529% increase in fourteen years since 2003.

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

Partially supportive

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.
In the event of the legalisation of assisted suicide, it would be imperative to form a new statutory body that would be held responsible, alongside the Chief Medical Officer, for collecting, reviewing, and reporting data on the practice of assisted suicide to the highest possible standard.

However, there are serious concerns as to the likelihood of such a body working effectively given the inadequate data collection practices in other jurisdictions where assisted suicide has been legalised.

Despite attempts to accurately monitor the practice of assisted suicide in Oregon, a 2005 study (https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.162.6.1060?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed) found that one particular patient was issued with a lethal prescription nearly two years before he actually died of natural causes after receiving compassionate care instead.

Concerningly, Oregon statute does not define participation under the DWDA as suicide. Instead, the Oregon Health Authority recommends that physicians record the terminal illness as the cause of death and the death as ‘natural’ (https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/faqs.aspx#deathcert). Any recording and reporting of data on assisted suicide should treat the cause of death as suicide, since it is the deliberate intervention to end the life of a person, rather than the passage of life and death through natural means.

A further concern in relation to the possibility of accurately recording and reporting data on the practice of assisted suicide, and particularly in relation to complications, is that the prescribing physician has been present at only 14.6% of deaths from assisted suicide in Oregon since 1998 (https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf
).

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

When considering the issue of conscientious objection, it must be emphasised that those medical professionals who are more involved in end-of-life care are less likely to support the legalisation of assisted suicide.

Any provision for conscientious objection must allow those objecting to abstain from referring a patient seeking assisted suicide to an able and willing medical professional. As argued by Roger Trigg, Emeritus Professor of Philosophy at the University of Warwick, in an article (https://pubmed.ncbi.nlm.nih.gov/27934565/) in the Cambridge Quarterly of Healthcare Ethics, "Even referring a patient to someone else, when what is in question may be assisted suicide, or euthanasia... involves some complicity [...] Physicians and others should not be coerced into involvement of any kind in

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what they regard as wrong. Such coercion goes against the very principles of liberal democracy." It is, therefore, deeply concerning to read that this proposal (https://www.parliament.scot/-/media/files/legislation/proposed-members-bills/assisted-dying-for-terminally-ill-adults-scotland-consultation-2021-final.pdf) for legalising assisted suicide would insist that "a referral to another consenting doctor should be made if the initial doctor declined to assist the patient because of their personal beliefs."

By still requiring an objecting doctor to provide an effective referral, thereby involving them in the delivery of assisted suicide to the patient, the proposal does not adequately respect the moral and spiritual concerns of the objecting doctor.

For Muslim professionals in particular, it is impossible to reconcile a bill which enforces someone to be anyway complicit with hastening of death with their fundamental religious belief of protecting life.

Worryingly, a British Columbia hospice society (https://www.cbc.ca/news/canada/british-columbia/bc-hospice-legal-funding-cut-province-1.5477556) has been embroiled in political and legal battle (including the removal of material support from their local health authority) for refusing to comply with provincial policies on medical assistance in dying which conflicted with its Christian character.

In March 2020, the Physicians' Alliance Against Euthanasia reported (https://alexschadenberg.blogspot.com/2020/03/press-release-growing-number-of.html) that a growing number of physicians are being bullied into participating in the provision of euthanasia or assisted suicide. Palliative care specialists have suffered particular distress, including the "betrayal of collegial relationships", which should be of deep concern to anyone considering introducing assisted suicide

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 increase 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.
Licensing doctors to provide lethal drugs to patients is not simply another form of treatment and crosses a Rubicon in medicine by sanctioning suicide as a form of healthcare. Any cost-benefit analysis of assisted suicide compared to expenditure on other forms of healthcare is flawed in principle. Abandoning ill patients to assisted suicide rather than providing life-sustaining treatment cannot be seen as cost-effective no matter how relatively inexpensive it might be, since it cannot be measured as another form of medicine and analysed on the same terms.

There should be deep concern that putting an economic "valuation" on individual human life could lead to treatment being refused for some individuals due to the lack of economic returns. In Canada, Roger Foley (https://www.ctvnews.ca/health/barely-hanging-on-to-life-roger-foley-shares-his-fight-for-home-care-with-un-envoy-1.4378334), an individual from Ontario who required expensive care but wanted to live 'was offered, among other things, medically assisted death'. Stephanie Packer, who was diagnosed with a terminal illness, said the company denied (https://www.insurancebusinessmag.com/us/news/breaking-news/insurer-offers-to-pay-for-assisted-suicide-but-not-chemotherapy-39441.aspx) her coverage for her treatments but offered to pay for assisted suicide after California passed a law allowing the measure in June 2016.

Legalising assisted suicide could lead to decreased investment in the vital care of those living with disabilities who could become eligible for assisted suicide instead. As noted (https://hansard.parliament.uk/Lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL)?highlight=simple%20fact#contribution-ADE5F199-9BA7-4129-

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:

8FE6-AD5F32C3ECF2) by the disabled peer Lord Shinkwin during the Second Reading debate on the Assisted Dying Bill [HL] last October, "It is a simple fact that keeping those of us with severe disabilities alive costs money—lots of it". Lord Shinkwin told (https://hansard.parliament.uk/Lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL)?highlight=simple%20fact#contribution-ADE5F199-9BA7-4129-8FE6-AD5F32C3ECF2) Parliament that, had assisted suicide become law, he would have "felt like a burden. If I had known then what we know now about the highly relevant assisted dying developments in Canada, I would have felt that a price had been placed on my head". Although the legalisation of assisted suicide may well cut costs in this regard, such financial saving would come at the much steeper cost of social and medical failure to properly cater for the needs of those living with disabilities.

We can expect that costs and demand for assisted suicide would increase following its legalisation, and that the budget allocation for proper healthcare as provided by the already stretched NHS would decrease.

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.
The legalisation of assisted suicide would have a profoundly negative impact on the equal treatment of those living with disabilities, particularly if their condition is considered terminal under this proposed legislation.

Also, the legislation actively discriminates against Muslim professionals and other professionals who consciously object. For Muslims in particular the bill will compel them to choose between their profession and their fundamental beliefs.

Laws send social messages. An assisted suicide law, however well-intended, would alter society's attitude towards those living with disabilities, sending the subliminal message that assisted suicide is an option they 'ought' to consider, particularly if their condition is considered to be terminal.

Disability advocates, including the Council of Canadians with Disabilities, have condemned (https://cacl.ca/2019/10/04/advocates-call-for-disability-rights-based-appeal-of-the-quebec-superior-courts-decision-in-truchon-gladu/) the 2019 ruling of the Quebec Superior Court to allow for assisted suicide in cases when death is not "reasonably foreseeable". They have argued (https://cacl.ca/2019/10/04/advocates-call-for-disability-rights-based-appeal-of-the-quebec-superior-courts-decision-in-truchon-gladu/) that the decision risks sending the message that "having a disability is a fate worse than death".

It cannot be ignored that all major disability rights groups in the United Kingdom (including Disability Rights UK (https://www.disabilityrightsuk.org/news/2015/september/our-position-proposed-assisted-dying-bill) , SCOPE (https://www.scope.org.uk/media/press-releases/scope-concerned-by-reported-relaxation-of-assisted-suicide-guidance/) , United Kingdom's Disabled People's Council (https://www.carenotkilling.org.uk/links/the-united-kingdoms-disabled-peoples-council-ukdpc/) , and Not Dead Yet UK (http://notdeadyetuk.org/)) oppose any change in the law.

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)?

No Response