Consultation on Liam McArthur's Assisted Dying for Terminally Ill Adults (Scotland) Bill

Response from:
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Views on the Proposal

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

'Fully opposed'

Please explain the reasons for your response.

CARE for Scotland is deeply concerned by the proposed Bill.

Ill-conceived: It assumes there are no ethical difficulties

1.1 We approach the debate by affirming the inherent value of every human life, regardless of age, stage of life, health, disability or any other factor. Introducing assisted suicide would integrate into our culture the belief that certain lives, far from being worthy of protection, merit the active intervention of doctors for the purpose of securing their demise. This is deeply problematic. Assisted dying' of the sort proposed by the Consultation would send a confusing and regressive signal that certain lives are no longer worth living, which would also undermine society's wider anti-suicide message.

Ill-conceived: It assumes death will be peaceful

1.2 The Consultation seems to be predicated, as is so much discussion on assisted suicide, on the assumption that accessing assisted suicide is a matter of simply having an injection, falling peacefully asleep and never waking up again. Nothing could be further from the truth. None of the safeguards **prevent complications on taking medication**, nor does the Consultation give any indication what *should* happen if there are complications. The evidence is clear that taking these lethal drugs is not always associated with a peaceful, dignified death but can

result in complications including regurgitation of the medicine, regaining consciousness and seizures; and that **death can take a long time**, up to 3 or 4 days in some cases.[1]

Ill-conceived: It assumes the law will not be extended beyond the terminally ill

1.3 Assisted suicide is always proposed, in whatever jurisdiction, in the context of 'rigorous safeguards' to prevent abuses but the international evidence is very clear that where assisted suicide has been available for some time these safeguards are always challenged and usually eroded. The original safeguards in place in Belgium[2] and the Netherlands[3] for example have been substantially eroded. Canada, meanwhile, which passed its assisted suicide legislation as recently as 2016 has already disposed of one its main safeguards, namely that assisted suicide can only be provided to someone whose death is "reasonably foreseeable"[4] and in March 2023 the law will allow a mental illness to be included in the definition of a grievous and irremediable medical condition.[5]

Ill-conceived: It assumes there will be no impact on the disabled

1.4 Baroness Campbell of Surbiton said "*the distinction between disability and terminal illness is a false one… The disabled person dependant on a ventilator is terminally ill if the ventilator is switched off… I am fearful that any change to the current law prohibiting assisted suicide may adversely affect how I, other disabled friends and the wider community of disabled people are treated in the future*".[6] CARE believes the proposal in this Consultation would be a regressive rather than progressive move which is likely to entrench a negative view of disability and the elderly.

Ill-conceived: It assumes there will be no conflict with a suicide prevention focus

1.5 Introducing a medicalised regime for certain suicides risks dismantling a protective factor against suicides more widely – the wholesale societal rejection of suicide as a tragic act. The timing of this renewed push for policy change is particularly inappropriate given that policies to prevent suicide have been a priority.

Ill-conceived: It assumes 'choice' will not become an obligation

1.6 A Canadian journal article highlighted the "*substantial savings"* on health care spending that could occur under their Medical Assistance in Dying law.[7] [8] At present people who realise that their treatment is expensive and/or feel that they are a burden do not have to consider 'doing the right thing' and accessing assisted suicide because it is illegal. If the current situation is turned on its head and assisted suicide is made a state sanctioned/regulated option, the right to die for some will inevitably become the duty to die for many more. In recent years, of those who received a prescription for lethal medication and die using either Oregon or Washington's State Death with Dignity Act more than 50% cited being a "*burden on family, friends/caregivers*" as one of their end-of-life concerns.[9]

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1 Oregon Death with Dignity Annual; Reports 1998-2019, quoting data from 2010, 2007, 2009, 2015, 2016, 2017, 2018, 2019; including 2019 pages 13 and 16; Washington Death with Dignity Annual Reports 2009-2018, including 2018 Table 4, page 13

2 Belgium approves assisted suicide for minors, *Deutsche Welle News*, 13 February 2014 http://www.dw.com/en/belgium-approves-assisted-suicide-for-minors/a-17429423

3 Jotkowitz A, Glick S, The Groningen Protocol: another perspective, *Journal of Medical Ethics*, Mar 2006, 32(3): 157-8 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2564470

4 BBC News Canada opens door to expanding assisted dying - BBC News (24.2.20; accessed 7.4.21)

5 https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html

6 Campbell, J, 'Disabled people like me fear legal assisted suicide: it suggests that some lives are less worth living', British Medical Journal, 6 February 2019

7 Trachtenberg AJ, Manns B, Cost analysis of medical assistance in dying in Canada, CMAJ, 2017 Jan 23;189(3):E101-E105. doi: 10.1503/cmaj.160650

8 Cost Estimate for Bill C-7 "Medical Assistance In Dying", Office of the Parliamentary Budge Officer, 20 October 2020, Tables 1 and 2, pages 1 and 2

9 Table 3, Washington State Death with Dignity Act Report 2019 (latest available); Oregon Death with Dignity Act Annual Report 2020, Table 1 page 12

1.7 As the Liberal Democrat Peer Baroness Jolly said recently: *"Thanks to the kindness and compassion of care-home workers, my mother was able to spend her final days in dignity with her family by her side as she peacefully passed away. Were the law to change and assisted dying become an option in instances such as this, my mother's end-of-life care might have been overshadowed by a dreadful choice of having to have a discussion with a doctor about helping her to take her own life. Our existing end-of-life laws and customs already work well. There is no space for assisted suicide, the introduction of which would risk soon being interpreted as a duty to die to relieve emotional burdens on others."*[10]

Ill-conceived: It fundamentally alters the relationship between doctor and patient

1.8 The proposals would also fundamentally alter the absolute duty of care and bond of trust that presently exists between doctors and their patients. We would urge proponents of the proposed Bill to carefully consider the views of the 175+ medics who co-signed an open letter to the Cabinet Secretary on 5 July 2021: *"The prohibition of killing is the safeguard. The current law is the protection for the vulnerable. Any change would threaten society's ability to safeguard vulnerable patients from abuse, it would undermine the trust the public places in physicians, would send a clear message to our frail, elderly and disabled patients about the value that society places on them as people."*[11]

Ill-timed: There is a short fall in other care choices

1.9 The Chairman of the Royal College of GPs has warned that years of underinvestment in GP services means that providing safe and personalised care for patients is "*becoming increasingly undoable*".[12] Patients are waiting a long time to receive care and may feel desperate about their situation.[13] In this context the following observation by UN experts about assisted suicide is of real concern. *"Even when access to medical assistance in dying is restricted to those at the end of life or with a terminal illness, people with disabilities, older persons…may feel subtly pressured to end their lives prematurely due to attitudinal barriers as well as the lack of appropriate services and support*.[14]

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

2.1 The proposed legislation is not required.

2.2 Absolute autonomy over the circumstances of death, and an elimination of all pain or distress in every case is not possible. However, actively seeking to maximise dignity at the time death, coupled with the best possible pain relief, is a vitally important goal. The best way to achieve these excellent aims is to adopt a razor-sharp focus on developing 'gold standard' world-class palliative care provision.

2.3 Pain management is a critical consideration. In Oregon in 2020, 32.7% of those who opted for assisted suicide said "inadequate pain control, or concern about it" was a reason for choosing assisted suicide.[15] In Washington in 2019, 41.3% cited concerns about pain[16] and in Canada in 2020, 50.6% did so.[17] Indeed, the Canadian report cites details from a practitioner who said,

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10 Letter to the Daily Telegraph, 12 October 2021
11 http://ourdutyofcare.org.uk
12 Martin Marshall: Media attacks on GPs threaten the doctor-patient relationship, BMJ Opinion, 10 September 2021
13 Record 5.6m people in England waiting for hospital treatment | NHS | The Guardian
14 Disability is not a reason to sanction medically assisted dying - UN experts, 25 January 2021
15 Oregon Death with Dignity Act Annual Report 2020, *Op Cit*, Table 1 page 12
16 Table 3, Washington State Death with Dignity Act Report 2019 (latest available)
17 Second Annual Report on Medical Assistance in Dying in Canada 2020, June 2021, Chart 4.3, page 20

"Upon admission to the palliative care unit for assessment by the first physician for a request for PAD, the patient was quickly relieved and taken care of in terms of care that was exhausting him at home (living alone). Adequate pain relief and appropriate care quickly led the patient to spontaneously conclude that he did not wish to die immediately, but to receive comfort care appropriate to his condition. The patient chose to cancel his PAD application spontaneously and voluntarily within hours of admission. His decision remained unchanged during the week."[18] Canada's report includes details of why people withdrew their request. In 2020, 22% of requests were withdrawn. Just under half of these were because *"palliative measures as sufficient"*.[19] In a journal article reviewing the first ten years of Oregon's law the authors said, *"…unrelieved pain is a truly unfortunate reason underlying MAID use, in that dedicated palliative care should be able to relieve physical discomfort in nearly all cases."*[20]

2.4 While there are many examples of excellent palliative medicine, provision can be patchy, and there is much room for improvement.

- Sue Ryder has warned that the palliative care sector is at serious risk from collapse due to chronic underfunding by government.[21]
- Hospice UK has estimated that as many as one in four people in the UK are not able to access the palliative and end of life care services and support needed.[22]
- Dr Sam Royston, Director of policy at Marie Curie said recently: "we need to ensure that palliative care is not a postcode lottery, as is now the case." [23]
- The Scottish Partnership for Palliative Care's recent report *Every Story's Ending* notes that: "*Despite being a huge part of what the health and social care system delivers each day, palliative and end of life care is often surprisingly invisible in policies, plans, strategies and particularly in the measurement of outcomes.*" The report lists a wide range of "*deficiencies*" with current palliative care provisions which have been "*identified by stakeholders, and represent scope for real improvement.*"[24]

2.5 We agree that "*Euthanasia and [Physician Assisted Suicide] do not solve the problem of inadequate symptom management or improving palliative care. These interventions are for the 1% not the 99% of dying patients. We still need to deal with the problem that confronts most dying patients: how to get optimal symptom relief, and how to avoid the hospital and stay at home in the final weeks. Legalising euthanasia and PAS is really a sideshow in end-of-life care — championed by the few for the few, extensively covered by the media, but not targeted to improve the care for most dying patients who still suffer.*"[25]

2.6 A 2020 article in the Canadian Family Physician journal, which commented: "*The gap in access to palliative care in Canada is concerning, as it is conceivable that those who do not receive adequate palliative care might have a higher burden of physical symptoms and potentially an increased likelihood of requesting MAID as a means to address their suffering*".[26] Statistics from the Canadian Second Annual MAID Report indicate that in 2020 126 patients who died by

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18 Second Annual Report on Medical Assistance in Dying in Canada 2020, June 2021, page 33
19 Second Annual Report on Medical Assistance in Dying in Canada 2020, June 2021, page 33
20 Blanke C et al, Oregon's Death With Dignity Act—Reply, *JAMA Oncol*. 2018;4(5):748. doi:10.1001/jamaoncol.2017.5323
21 'It's time to end the hospice funding crisis', Sue Ryder blog, 8 March 2021
22 Equality in hospice and end of life care: challenges and change, *Hospice UK*, Page 6, 2021
23 Letter to The Times, 24 September 2021
24 EVERY STORY'S ENDING Proposals to improve people's experiences of living with serious illness, dying and bereavement in Scotland, Scottish Partnership for Palliative Care, September 2021, pages 22 and 132
25 Emanuel E, Euthanasia and physician-assisted suicide: focus on the data, Vol 206(8), 339-340, May 2017, Medical Journal of Australia, https://doi.org/10.5694/mja16.00132
26 Munro, C, Romanova, A, Webber, C et al., Involvement of palliative care in patients requesting medical assistance in dying, Canadian Family Physician November 2020, 66 (11) 833-842

assisted suicide neither received nor were able to access palliative care if they needed it, and the accessibility of palliative care was unknown in an additional 170 cases.[27]

2.7 **There is a huge risk that this lack of choice of palliative care combined with the provision of a state sanctioned/state regulated assisted suicide will result in some terminally patients reluctantly opting for an assisted death when they would have preferred to live their life to completion with appropriate symptom relief**. We would urge the Bill proposer to redirect the focus upon campaigning and/or legislating for these sorts of improvements. As Pamala McDougall, a retired former nurse, midwife, health visitor and counsellor with 50 years' experience wrote recently: *"My main reason for opposing this Bill is that it is unnecessary. I have seen what a difference good quality palliative care can do to alleviate pain, fear and distress. We must focus on providing training, funding, and political will to provide the best possible care, to make this Bill redundant.* [28]

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

'Fully opposed'

Please explain the reasons for your response.

3.1 CARE for Scotland opposes the principle of 'assisted dying' and therefore opposes the steps to actively bring it about.

3.2 In terms of the steps set out in the Bill, we note that the definition of a terminal illness is not based on living for a certain amount of time (eg. six months as in Oregon and Victoria), but an open ended time limit based on the definition of a terminal illness used in benefits legislation in Scotland, the Social Security (Scotland) Act 2018, Schedule 5, para 1(2). This is a significantly different regime from others operating around the world. A declaration by medical professionals that a person has the capacity to make a life-ending decision would need to be rigorous to ensure that other factors were not leading to a person's decision to end their life – for instance depression which could be treated may be a factor in a person's request,[29] [30] or feeling a burden (as referenced above), or being subject to 'invisible' coercion. Oregon, Victoria and Canada only allow a person aged 18 and over to make a decision to end their life through assisted suicide. Scotland proposes that assisted suicide would be available to someone aged 16 and over.

3.3 The notion of a sick and vulnerable person, under step 3 (Prescribing/delivering), subsequently ingesting a lethal dose of medicine, is an act bereft of compassion, and is at wholly at odds with attempts to drive down suicides in all other contexts.

3.4 Questions also remain unanswered about the effectiveness of prescribed medicines, and to what extent the ensuing process of death is pain free. As Dr Joel B Zivot, associate professor of anaesthesiology and surgery at Emory School of Medicine in Atlanta recently explained: *"Assisted suicide and execution by lethal injection in the United States use the same drugs and this is a cause for serious concern. From my work reviewing autopsies on death row inmates in the US I found that many of those who were executed by lethal injection developed*

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27 Second Annual Report on Medical Assistance in Dying in Canada 2020, Health Canada, June 2021, Table 4.4

28 Letter to The Scotsman, 2 October 2021

29 W Breitbart; B Rosenfeld; C Gibson; M Kramer; Y Li; A Tomarken; C Nelson; H Pessin; J Esch; M Galietta; N Garcia; J Brechtl; M Schuster, Impact of treatment for depression on desire for hastened death in patients with advanced AIDS, *Psychosomatics*, 2010 Mar; 51(2): 98-105

30 Ganzini L, Goy ER, Dosbcha SK, Prevalence of Depression and Anxiety in Patients Requesting Physicians' Aid in Dying: Cross Sectional Survey, *British Medical Journal*, 8 October 2008; 337; a1682

pulmonary oedema: the lungs filled with fluid. This occurred as they died and in effect was similar to death by drowning. Examples of distress and breathlessness are known in such cases." [31]

3.5 Rather than focus upon the mechanical "process for assisted dying", better by far to channel efforts in supporting life. As the Scottish Partnership for Palliative Care stated recently: *"While 'dying well' is important, it is only part of what matters – emphasis should always be on optimising wellbeing for as long as someone remains alive, whether that turns out to be years, months or hours – a focus on living well, not on dying."*[32]

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.

4.1 CARE for Scotland is wholly unconvinced by the effectiveness of any so-called 'safeguards'. Even a cursory examination of the small number of jurisdictions where a form of assisted dying has been legalised shows that criteria are widened, and safeguards simultaneously eroded, over time. Lord Falconer, talking about a similar proposal, admitted: *"I don't think you can ever have a system that is completely watertight."*[33]

4.2 In Canada, the relatively recent 'medical assistance in dying' law (MAID) is to be expanded to those with mental illness.[34]

4.3 Once a practice is legalised, it soon becomes normalised, and it would be a matter of time before restrictions would be progressively removed as the criteria expand. As Lord Wallace of Tankerness put it recently, *"The current societal protection of life is clear and to move away from this would…represent a 'crossing of the Rubicon' from which there would be no return. This would have profound effects on how society regards those in our communities who are vulnerable, not just the elderly and infirm but also those with disabilities and those who are unable to speak up to protect themselves.* [35]

4.4 Ultimately, no safeguards can compensate for the fact that in an overstretched healthcare system, the potential for a person to feel a burden for taking up resources increases. The blanket application of Do Not Attempt CPR (DNR) orders during the coronavirus pandemic for the elderly communicated to this group that their potential to become 'bed blockers' represented a threat to the operation of the NHS. Age UK reported that vulnerable people, who felt pressurised into signing DNR forms during the Covid outbreak were made to feel that their lives and wishes did not matter. [36] If a patient can feel socially obliged to accept a DNR order, they can be made to feel similarly obliged to opt for assisted suicide. In January 2021, UN experts said, "people with disabilities, older persons…may feel subtly pressured to end their lives prematurely due to attitudinal barriers as well as the lack of appropriate services and support. [37]

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31 Comment in The Times, 22 September 2021
32 EVERY STORY'S ENDING, *Op Cit*, page 52
33 http://www.dailymail.co.uk/news/article-2082930/Assisted-death-plan-risky-admits-Falconer-says-completely-watertight.html?printingPage=true
34 https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html
35 The Times, 24 September 2021
36 Age UK, Age UK, Response to DNR forms during Covid-19 crisis, 7 April 2020
37 Disability is not a reason to sanction medically assisted dying – UN experts, 25 January 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

5.1 Such a body would not be required if the legislation were to be abandoned.

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

6.1 If the provisions of the Consultation were implemented, robust provision for conscientious objection, covering both direct and indirect involvement in assisted deaths, would be essential. The right to conscience under Article 9 of the ECHR[38] and Resolution 1763(2010) of The Parliamentary Assembly of the Council of Europe[39] would need to be upheld and should ensure that no person would be required to participate in any part of the process – including providing information nor any medical professionals required to refer a patient to another doctor, which would be in line with current GMC Guidance.[40] It is nevertheless of concern that it may not be possible, to maintain these requirements over time as protections could be eroded by the Courts. Indeed, in Canada since the introduction of assisted suicide, conscientious protection for doctors has been undermined.[41]

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'

7.1 Whilst we don't know for certain what the financial implications of the proposed Bill would be, evidence from overseas – allied with acknowledged costs of health care currently – is instructive. CARE for Scotland is deeply troubled by footnote 124 (pages 28-9) of the Bill proposals which highlight the multi-million dollar cost savings of assisted dying in Canada. The inclusion of this information at the very least concedes (and arguably actively promotes) the argument that it is cheaper to end life than to provide care. If the financial cost of a dose of lethal medicine is dwarfed by the eye-watering costs of health and social care (as the information in note 124 appears to explicitly suggest) then this further heightens concerns about pressure and coercion.

7.2 The Nuffield Trust has stated that "*the cost of hospital care at the end of life is substantial*".[42] The cost of an adult staying in hospital specialist palliative care is estimated to be £447 per day.[43] The Sue Ryder website states that inpatient hospice care costs £500 per day and a hospice nurse £3,000 a month.[44] In 2017, the cost of drugs for the Canadian Medical Assistance in Dying (MAID) was estimated to be between CAD$25.40-$326 (£14.83-£190.29).[45] [46] Figures published in Canada in 2020 for the reduction in health care costs under the Canadian MAID

38 http://www.echr.coe.int/Documents/Convention_ENG.pdf, p.10
39 http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=17909
40 https://www.gmc-uk.org/-/media/documents/personal-beliefs-and-medical-practice-20200217_pdf-58833376.pdf
41 The Globe and Mail, 15 May 2019, see https://www.theglobeandmail.com/canada/article-religious-doctors-must-make-referrals-for-assisted-dying-abortion/ as at 15 July 2019
42 The Nuffield Trust, 'Exploring the cost of care at the end of life' September 2014, page 17
43 Curtis, Lesley A. and Burns, Amanda (2020) Unit Costs of Health & Social Care 2020. PSSRU, University of Kent, page 87. Translates to £3,129 per week
44 https://www.sueryder.org/support-us/make-a-donation/how-we-spend-your-donations Accessed 4 October 2021
45 Trachtenberg AJ, Manns B, Cost analysis of medical assistance in dying in Canada, CMAJ, 2017 Jan 23;189(3):E101-E105. Figures referred to are in Table 1 doi: 10.1503/cmaj.160650
46 Using Financial Times currency conversation rate of 1 CAD=0.5837 GBP of as 4 October 2021

regime estimates that for 2021 alone it would equate to CAD$149m (£86.97m) and a reduction of 0.08% in health care budgets.[47]

7.3 While deliberate coercion could be a problem in extreme cases, a far wider, and inevitable, result of the proposed legislation would be very sick and vulnerable people feeling an invisible pressure to at least consider assisted suicide out of fear of being an emotional or financial burden upon family or an already woefully over-stretched NHS. To add this pressure onto already sick and vulnerable people would not be an act of compassion.

7.4 Policy and the law should uphold the care of those with terminal and other chronic illnesses and their carers, not add to the feeling of being a burden.

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'

8.1 As the overwhelming majority of people who would qualify for assisted dying under these proposals would be elderly, it is evident the proposals will have a negative impact on the elderly. For every one that might appreciate the supposed 'choice', there would be many, many more who would be burdened with unbearable pressure of having to decide, which would be extremely damaging to their wellbeing. As Professor Rob George, Consultant in palliative medicine, said: "Every conversation with a dying person would change: death would become a treatment to discuss, and people for whom we care would have to hear it."[48]

8.2 The proposed Bill would send a negative message to those with a terminal illness, and arguably to people with other illness or disabilities, that certain lives are no longer worth living. Not Dead Yet UK state, *"Individuals risk being easily exploited by the 'right-to-die' movement or, worse, by family, friends and health care professionals. Their attitude is not compassionate – it is prejudiced and disablist. We oppose policies that single out individuals for legalised killing based on their medical condition or prognosis."*[49]

8.3 Similarly, Pam Duncan-Glancy MSP has said: "*Unless and until all things are equal, which we know right now they are not, then this bill is dangerous for disabled people.*"[50]

8.4 Assisted suicide, by definition, sends a clear signal that certain lives are no longer worth living. It is also individuals in these categories who are most likely to feel pressurised into considering assisted dying. In the absence of the Bill, such pressure would not exist.

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**

47 Cost Estimate for Bill C-7 "Medical Assistance In Dying", Office of the Parliamentary Budge Officer, 20 October 2020, Tables 1 and 2, pages 1 and 2

48 Letter to The Times, 23 September 2021

49 http://notdeadyetuk.org/about/ - see What is NDYUK's position; accessed 14 December 2021

50 The Scotsman, 22 June 2021

- **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'

9.1 The Bill's proposals represent the antithesis of "a strong, healthy and just society" because rather than care for the most vulnerable people in society, we would be presenting them with the option of premature termination of their lives.

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)?

10.1 CARE for Scotland understands that the motivation for some of the proposers is to minimise pain and suffering at time of death. Enhanced dignity near to death is extremely important but is not to be found in the authorised termination of a life. Hard cases inevitably make bad laws, and as Dr Katherine Sleeman (King's College, London) has stated, "*it's wrong and dangerous to frame this as a choice between suffering and suicide*."[51]

10.2 We would sincerely plead the proposers to consider again the pressure which these measures would place upon some of the most vulnerable people in Scotland; to withdraw these proposals, and to refocus precious parliamentary time and resource on better palliative care. The words contained in the Scottish Partnership for Palliative Care's recent report bear repeating, *"While 'dying well' is important, it is only part of what matters – emphasis should always be on optimising wellbeing for as long as someone remains alive, whether that turns out to be years, months or hours – a focus on living well, not on dying."* [52]

51 https://www.spiked-online.com/2021/06/22/scotland-must-say-no-to-assisted-suicide/
https://www.dyingwell.co.uk/watch-secretary-of-state-matt-hancock-at-the-dying-well-appg/

52 EVERY STORY'S ENDING, *Op Cit*, page 52