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.

an individual

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".)

Member of the public

Please select the category which best describes your organisation

No Response

Please choose one of the following:

I would like this response to be published anonymously

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).

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.
The Bill is attempting to lay down rules and procedures we must follow for death and dying Managing death and dying is too complex and sometimes ‘not tidy’.
The issue lying behind the proposed Bill is how society and individuals within that society face suffering, dying and death. Living with suffering is hard. There is a strong tradition within palliative care of embracing

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the tensions and finding a way to cope with ‘the intolerable’.
Suffering, dying and death are an integral part of living and life. Paradoxically it is by living with and working through the crisis of illness and the challenges of suffering that humanity actually becomes more compassionate and mature. We need a conversation in society about death and dying. People live and die within the framework of a story. Suffering and intolerable despair is always contextual. The Bill needs to give more recognition to the human process.
People’s emotional, psychological and spiritual well-being change from day to day, and in end of life care from hour to hour.
There is a lack of evidence that the proposed legislation is actually needed in our society. A need and support for the Bill is based primarily on Data and detail from other jurisdictions/Countries. The proposals are modelled on legislation that has passed rigorous testing in other countries around the world. They are different cultures entirely. Different values Mr McArthur is assuming we will meet similar problems and have similar solutions and outcomes ? How can he be so sure? Again and again the individual who in their homes ask to be given an exit pill/concoction, if illness comes their way; in the reality and context of end of life care strived to hold on to life firmly. This Bill’s focus is to legislate for the intentional ending of life. The Bill seems to be addressed to a minority of people who are burdened with the very subjective experience of ‘intolerable despair’. But written in such a way that the scope extends to a vast number within society. There is a danger that the Bill will prejudice the safeguards of the majority for the sake of an articulate minority. There is hesitation about accepting the proposed Bill because if accepted the legislation would ‘validate despair’; the way society faces difficult situations of suffering and distress would be radically and irrevocably changed. Whose need is being served by this Bill? The patient, or society?
What is ethically clear is that no individual can make choices and decisions that have no bearing on either their immediate family or wider on society as a whole. Decisions to end one’s life affect all of society. It certainly should not be left up to the medical profession to make ethical decisions which affect society as a whole How can one define or describe a life which has become ‘intolerable’?
Often it is the fear rather than the actuality that drives the desire for assisted dying, and people often change their minds. The bill is silent about post-mortem inquiry/investigation. Reporting of recent cases implies that 'helping' relatives shouldn't be prosecuted. The state must investigate and report the deaths of all citizens.
What impact for participants involved in end of life assistance will have on individuals and society. Will healthcare professionals become hardened against taking life?
Like legalising abortion, assisted suicide will escalate into a monstrous situation.
Assisted dying may sound compassionate, offering relief to those who feel their lives are intolerable. But if you look at the countries where it has already been legalised, a bleak picture starts to emerge.
Criteria for who could access assisted suicide and euthanasia were continually expanded.
The Canadian parliament scrapped the requirement for patients to have a fatal or terminal condition.
Assisted suicide was supposed to be a limited practice for only the most serious cases of terminal illness, but it is becoming an increasingly mainstream intervention in healthcare.
Proponents of Assisted Suicide like Mr McArthur know this proposal will lead to the gold standard of full blown Euthanasia. The slippery slope.

Pain is treatable. Killing is irreversible.
The doctor or nurse would become the most dangerous person in the state.
It can never be in society's interests that medicine should be turned into a Death Service instead of a Health Service.

I urge the Government to drop this proposed Bill.
It is quite astonishing that despite its apparent obsession with Human Rights, the Scottish Parliament could unwittingly help undo the most fundamental right of all - the right to life.

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.

The proposed Bill is unclear about where it really stands on palliative care. It recognizes its operation in Scotland but is not convinced by what it has to offer in controlling pain. Unfortunately high quality care is not available to all and I support an increased allocation of resources into palliative and end of life care. If there are times when quality end of life care does not occur this should motivate the Scottish Government to invest more resources in palliative care. I am seriously concerned that enacting this bill will at least seriously undermine and even destroy the current practice of palliative care in Scotland. How competent are medical personnel to "explain" hospice/palliative care? Might it be necessary to experience it in order

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to understand it?
If a patient did give their "consent" what would that mean?
Many people in distress are simply not capable of making such a momentous decision.
After all, none of us would willingly allow a distraught, would be suicide to jump off a tall building just because they insisted they wanted to.
We would stop them because we would know that they were in no fit state to make such a decision.

Proponents of the proposal seem to view human nature as simple.
It isn't. And that is why messing about in this particular minefield is so dangerous.
Not because advocates of assisted dying are acting in bad faith, but because they have little conception of how complicated situations can be.
And the slippery slope argument? It's real, it's as honest a fear as that of suffering and there are good reasons to be concerned.
The history of the good death is a very ugly one - Dignitas, Zurich - and only a historical illiterate would pretend it wasn't and ignore it.

The elevation of rights and autonomy over all, which underpins the associated euthanasia / assisted suicide campaign - which really means "survival of the fittest" and the extermination of the vulnerable sick, elderly and disabled, frail Scots - is this the ethos, the ethics of our future enlightened Scottish society?
Up to now we have always said no.

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.
Requiring the presence of the doctor or healthcare professional HCP could provide subtle emotional pressure on the patient to take the lethal medication. In Switzerland, guidelines indicate that the prescribing doctor should not be present when the patient takes the lethal medication, to avoid any form of emotional manipulation.
The presence of a medical professional cannot, therefore, be straightforwardly presented as a safeguard.

Not one organisation for disabled and terminally ill people has campaigned PUBLICLY for the changes proposed. They want help to live – not help to die.
"We don't kill our sick we care for them."

If assisted suicide was legalised, most physicians who care for terminally ill patients would not be willing to participate in the practice.

Pressure to legalise physician-assisted suicide betrays society's trepidation concerning death.
We are replacing the sanctity of life with the quality of life.
In Holland old sick people ask their families not to take them to hospital there and drive a little longer to reach a German one.

Since the time of Hippocrates in the fifth century BC (and no doubt before then) medical ethics has sought to ensure that doctors dedicate their skills completely to life and to healing, not to killing and suicide.
The 1949 International Code of Medical Ethics states: "A DOCTOR MUST ALWAYS bear in mind the Obligation of preserving human life.

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 promise -that Assisted Suicide puts the dying in charge, that he/she will be kept from torment - is wickedly false.
Assisted Suicide is unpleasant to observe.
Medication often cause violent convulsions and muscle spasms.
They may not die immediately – death can take many hours - and may require a Doctor eventually to provide a lethal injection.

I am deeply worried about this. Disabled people feel they do not yet enjoy their right to live equally. I'd far rather they had a right to live enshrined in law... This is dangerous for disabled people
The law should continue to criminalise assistance in suicide.

I have grave concern over the vulnerability of a 16 year old in being able to make such a decision. They are at a very difficult stage in their life and just learning the realities of decision making. It is wrong to give them the scope to end their lives. Rigorous prevention must be applied.
The physician has to be satisfied that the patient has unbearable suffering - without any test as to whether that suffering can be relieved. Also the request is the settled will of the 'requesting person' and that it has not been made as the result of pressure from any source whatsoever.
So these are not solid safeguards at all.
When the doctor feels unable to do more it becomes easy to see death as a therapeutic option - a quick and easy solution to a very complex problem. The "slippery slope" is very real.

A process that is intended to end the life of a person can never be considered safe.
This is an opportunity to make sure all options have been explored and to refer the person for psychiatric assessment if necessary. The person would be empowered to change their mind at any point. Remember First , do no harm.

The very fact of informing a patient that assisted suicide is an option could create pressure on a vulnerable patient. The language commonly used to the effect that assisted suicide is "dying with dignity" suggests to people that their illness and suffering are undignified. To vulnerable people at the most difficult stage of their life, that language itself creates pressure. Who wants to be undignified?

The purpose of the Law is to protect fundamental human values, fundamental human rights.
Should the "survival of the fittest" really be the character, the ethos,the ethics of Modern Scottish society?

Suicide is not dying naturally, and assisted suicide is not 'helping someone to die'. It is assisting self-killing.

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.
Creating a body responsible for reporting and collecting data cannot address possible abuse.
Since legalised assisted suicide is shielded by doctor-patient confidentiality, "in effect, any physician-assisted suicide regulation must, in the end, be physician self-regulated".
This is NOT acceptable and will be open to abuse. What body will investigate allegations of abuse by HCPs including misrepresentations on official forms.?

Will the public be informed when the Law has been broken ?

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

The State cannot dictate above conscience. A great part of conscience involves knowing what is right so as to do what is right.
Conscience is more than mere "opinion"; it implies convictions which go to the heart of who the doctor really is as a person.
Could Scotland reach a point where it is forbidden to have a conscience?
Public conscience is becoming more and more insensitive to moral issues.

Reasonable accommodation of conscientious objection is a matter both of liberty and equality: of individual freedom and social inclusion.
No one should be coerced by the risk to their careers into violating their conscience
A fundamental principle that has to underpin any proposals for regulation is that the freedom of conscience of individuals must be respected. It is not licit to force an individual to act contrary to his moral belief.

The conscience objection is formed by truth not by force.
The document states that doctors would be required to refer patients to another doctor for assisted suicide.
Doctors/Nurses who are clearest about their duties to their suicidal patients will refuse to do this?
Rights of conscience cannot be made subject to legislation, however well meaning

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:

some 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.
I support fully financed PALLIATIVE CARE in all regions throughout Scotland. It has never been seriously adopted in Scotland.

I'm not sure this is ethical way forward for an SNP government. A Scottish society that normalises suicide because life is reduced to a commodity, a cost, an asset and is therefore treated economically.
If an individual's worth is based on their current or anticipated economic value they then become soft targets for cost cutting.

The least costly treatment for any illness is lethal medication. Is this the way the Scottish Health Professionals and NHS business leaders are heading? I hope not!!

When society decides that certain types of killing are moral and less costly the door is opened to many others.
The mentally ill, the elderly, indeed anyone that society might consider to be obsolete, worthless, no longer productive or expensive to keep could be considered expendable in time.

Mr. McArthur can offer no guarantees that pressure on NHS budgets will not gradually lead to administrative policies that would view the promotion of assisted suicide as the preferred, possibly the only, treatment option for patients seen as a drain on NHS resources.
It is especially worrying that the question of costs is being raised at a time when people have been urged to "save the NHS" during the Covid crisis. No suggestion should ever be made that hastening one’s death would reduce costs for the NHS.

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.
Many disabled people fear assisted suicide. It is opposed by UK organisations working closely with and on behalf of disabled people.
Legalising assisted dying would be the beginning of 'unsanctifying' human lives, getting rid of the principle of equality where our lives are all equally valued.
You cannot say something is equal if it does not produce the same results!

In 1994 House of Lords medical committee rejected a proposal to alter the legal status of euthanasia in Britain.
The peers described the PROHIBITION of INTENTIONAL killing as the "cornerstone" of justice and equality.
I believe that the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life

It is plainly inconsistent with the principles of equality legislation to move in future to exclude some Scottish citizens from areas of medical employment simply because of their moral beliefs.

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

Please explain the reasons for your response.
A fundamental aspect of sustainable development is ensuring that economic, cultural and political systems do not favour some people while harming others.
As a result of introducing sustainability it's quite easy to then argue that
people who can't afford to go abroad, who are too poor or too sick, are being DISCRIMINATED against.
This is not a reason for introducing assisted suicide into Scotland.

Achieving a sustainable economy" in relation to assisted suicide implies that dying or ill people should take the cost of their treatment into consideration. This is coercive and has no place in a civilised society.

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)?

The Bill does not explore the deep impact of ‘end of life assistance’ on individuals; families, carers, and society as a whole. Support for the Bill comes from a few opinion polls, surveys etc: the reality of working with people at the end of their life shows that the experience of living with the end of life issues is very different from abstract discussion when death and dying is distant. There is too much ambiguity and too little thought given to the impact of the Bill on society as a whole.
Population control and assisted suicide could be construed as close relatives.

While personal autonomy is to be upheld as a value, laws stand as signs that there are other values espoused by society which take precedence over these.

The one thing that "dignity in dying" does not at present mean is assisted suicide.

Suicide is a tragic, individual act.
Physician Assisted Suicide is not about a private act. It's about letting one person facilitate the death of another.

If assisted suicide is legalised then this indicates that capital punishment is institutionally acceptable once more and opens up a pandora’s box and as an example gives a reason to long term prison inmates to request assisted suicide.
Politicians of all parties must ensure that the incremental approach to cheapening human life is not permitted.

Experience in end of life care shows that people change their views right up to their last breathe.
Palliative care specialists are worried that in a context of end of life care where over 50% of people suffer from depression or adjustment disorders that a healthcare professional can discern who is competent to make such significant decisions. Waiting period between requests should be longer
The designation "terminally ill" is subjective, imprecise and therefore inappropriate for legislation such as this. Prognoses (e.g. 6 months, 12 months) are notoriously unreliable. There is no provision for any precise consideration of mood as a factor in prompting people to contemplate euthanasia. Research from Oregon reveals that as many as one in six people who commit suicide with the help of their doctors is suffering from treatable but undetected depression.