Response ID ANON-RS6Y-1XRK-T

Submitted to Assisted Dying for Terminally Ill Adults (Scotland) Bill: Detailed Consultation – Call for Views
Submitted on 2024-07-15 12:36:53

About you

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Important information about responding to this consultation

I confirm I have read the information above and would like my response to be published in its entirety

What is your name?

Name:
Better Way

What is your email address?

Email:
admin@betterwaycampaign.co.uk

Are you responding as an individual or on behalf of an organisation?

Organisation

Organisation details

Name of organisation

Name of organisation:
Better Way

Information about your organisation

Please add information about your organisation in the box below:

Better Way opposes assisted suicide, sets out an alternative vision, and provides a platform for marginalised voices. The campaign is supported by experts in several fields including medicine, disability advocacy, and sociology.

Question 1 - Overarching question

Which of the following best reflects your views on the Bill?

Strongly oppose

Space for further comment on your answer:

In our view, 'assisted dying' is still not safe. Indeed, we believe it will never be. Allowing this practice in Scotland would give rise to profound injustices. Injustices that affect disabled Scots, Scots facing poverty, Scots who are isolated and lonely, and many others. No amount of legal drafting can rule out Scottish citizens choosing to end their lives because they lack sufficient support to go on living. This, in itself, should prevent a change in the law.

Doctors warn that 'assisted dying' would undermine palliative care for all Scots. Psychiatrists warn of a harmful shift in our societal response to suicide. And sociologists caution that a change in the law may open the door to more permissive legislation in years to come. The tragic experience of other nations suggests it is a matter of when, not if, laws expand.

Opposition to a change in the law is found among people with different beliefs – atheists, humanists, agnostics, and people of faith. It is motivated by both personal and professional insights. Our campaign seeks to present a range of arguments, from diverse perspectives.

Note on terminology:

Our supporters regret that campaigners for 'assisted dying' employ misleading language that distracts from the practical implications of what's proposed in this legislation. Studies reveal differing views about what, precisely, the public understands by this term, with answers ranging from the withdrawal of life-sustaining treatment to palliative care (1).

For the avoidance of doubt, what is being advocated is a system where persons diagnosed with a terminal illness can access drugs from medical professionals to ingest in order to end their lives. Our supporters believe the most-accurate term for this process is "assisted suicide". A past proposal from the late Margo MacDonald MSP used this term.

(1) https://www.dyingwell.co.uk/survation-appg-for-dying-well-survey-july-2021/

Which of the following factors are most important to you when considering the issue of assisted dying? Please rank a maximum of three options.

ranking important factors - Impact on healthcare professionals and the doctor/patient relationship:
1

ranking important factors - Personal autonomy:

ranking important factors - Personal dignity:

ranking important factors - Reducing suffering:

ranking important factors - Risk of coercion of vulnerable people:
2

ranking important factors - Risk of devaluing lives of vulnerable groups:

ranking important factors - Sanctity of life:

ranking important factors - Risk of eligibility being broadened and safeguards reduced over time:
3

ranking important factors - Other – please provide further details in the text box (200 characters max):

If you selected Other, please provide your answer in the text box below:

Space for further comment on your answer:

Impact on healthcare professionals:

Campaigners assert that assisted suicide can be introduced alongside existing end-of-life care without issue. However, our doctor allies believe it would have a hugely negative impact. They highlight research evidence on the effects of assisted suicide and euthanasia laws on palliative medicine access, hospice funding, and physicians (1).

Survey data shows that a significant majority of palliative care doctors in Scotland oppose assisted suicide (2).

Coercion and pressure:

Proponents argue that safeguards can ensure that overt forms of coercion are spotted. We do not believe this is possible, given doctors' inability to screen patients properly for this issue. Coercion takes various forms and can be very subtle. In any case, other, less overt, pressures would come into play when a person is considering the option of assisted death.

Ultimately, patients' decisions would be influenced, unjustly, by their socio-economic status, access to specialist care, and experience of various hardships such as loneliness, addiction, homelessness, relationship breakdown, and past trauma. Some patients may also feel that they are a burden on loved ones, or wider society. Others may feel that they should opt to end their lives in order to ensure that their inheritance is not spent on paying for care.

Mission creep:

Both countries that have long-standing assisted suicide or euthanasia laws and countries that have introduced laws in the last decade have witnessed significant expansion. In other contexts, we are witnessing constant pressure to expand legislation. This includes more recent laws frequently cited by 'assisted dying' campaigners.

(1) https://ehospice.com/editorial_posts/the-impact-of-assisted-dying-on-hospices-and-palliative-care/

(2) https://apmonline.org/wp-content/uploads/2023/02/APM-Survey-of-AD-Impact-on-PC-FINAL.pdf

Question 2 - Eligibility

Which of the following most closely matches your opinion on the terminal illness criterion for determining eligibility for assisted dying?

No-one should be eligible for assisted dying

If you selected Other, please provide your answer in the text box below:

Space for further comment on your answer:

‘Terminal illness’ definition:

The definition of terminal illness in the Bill - an “advanced”, “progressive” condition that a patient is “unable to recover” from, which is expected to cause their “premature death” – is very broad. At present, it could catch patients suffering from anorexia, and some disabilities.

The bill also creates confusion on whether a person with dementia is eligible. On one hand, dementia is a progressive, incurable condition that causes a person to die prematurely. This should make people with the condition eligible. On the other hand, it is intended that persons with a mental disorder should be excluded. This contradiction is not addressed.

The requirement in Section 3 that a person should be “ordinarily resident” in Scotland for at least 12 months raises the spectre of ‘suicide tourism’, whereby persons with terminal illness in other parts of the UK make their home in Scotland in order to access assisted suicide. This would compound pressures on NHS Scotland and impact ethically divergent patient care in England, Wales, and NI.

Which of the following most closely matches your opinion on the minimum age at which people should be eligible for assisted dying?

No-one should be eligible for assisted dying.

If you selected Other, please provide your answer in the text box below:

Space for further comment on your answer:

It’s concerning that 16-year-old children are deemed eligible. The Scottish Partnership for Palliative Care has said: “In young people the age of legal mental capacity to give consent should not be assumed to be the same as the age at which an individual achieves the cognitive and emotional ability to make a particular decision”.

Question 3 - The Assisted Dying procedure and procedural safeguards

Which of the following most closely matches your opinion on the Assisted Dying procedure and the procedural safeguards set out in the Bill?

Other – please provide further details in the text box (200 characters max)

If you selected Other, please provide your answer in the text box below:

Our expert allies believe it is impossible to prevent abuses - there is no way to make assisted suicide 'safe'.

Space for further comment on your answer:

Examination by two doctors:

Doctor assessments do not include consideration of the patient’s wider circumstances, including their social status, family situation, access to support etc.

The involvement of a second “independent registered medical practitioner” is presented as a safeguard. It could be seen as the opposite. This professional’s lack of involvement with a patient means they are less likely to know of information in their medical or personal history that could be a cause for concern.

Section 7 specifies that doctors should consider an applicant’s “diagnosis and prognosis”. It’s important to stress that doctors’ opinions are fallible, and not infrequently wrong.

Test of non-coercion:

Sections 6, 8 and 15 specify that medical practitioners must ensure that a patient requested assisted suicide “voluntarily and has not been coerced or pressured by any other person”. We would submit that doctors are wholly unprepared to make this judgment, given that coercion can be subtle and hard to detect. Such assessments are inherently fallible and cannot be considered a ‘safeguard’.

There is no provision for assessment of pressures arising from a patient’s background or wider circumstances. As we have warned, a person’s decision to opt for assisted death will be affected by their experience of healthcare inequality, loneliness, poverty, family breakdown, addiction, and a host of other potential factors. People would inevitably opt to die because they lack sufficient support to live.

Period of reflection:

The suggested reflection period of 14 days (Section 9) – or 48 hours if a person’s death is thought to be imminent – is alarming and should not be considered a safeguard. Both psychiatrists and palliative doctors stress the potential for patients to adjust their outlook over a longer period, especially if new or additional forms of support become available. The two-week period diminishes patient choice.

Question 4 – Method of dying

Which of the following most closely matches your opinion on this aspect of the Bill?

It should remain unlawful to supply people with a substance for the purpose of ending their own life.

If you selected Other, please provide your answer in the text box below:

Space for further comment on your answer:

Campaigners for assisted suicide believe it should be an option and describe it as a “safe and comfortable death” (1). Our allies, expert medics in relevant fields, reject this claim.

A 2022 research paper in the British Medical Bulletin concluded that: "Evidence from jurisdictions where assisted suicide is legal reveals that some patients who ingest the prescribed lethal drugs experience distressing complications. There is also evidence that the drugs used for assisted suicide do not consistently bring about death quickly" (2).

Recent data from the state of Oregon paints a concerning picture (3).

Data on the duration of death is recorded for 1,306 of the 2,384 people who died via assisted death between 2001 and 2022. Of this number: 87 took more than six hours to die; 368 took between one and 6 hours to die; 851 took one hour or less to die.

Data on complications occurring is available for 906 of the 2,454 people who died via assisted death between 1998 and 2022. Of this number, almost 1 in 10 had serious complications. These included difficulty ingesting, vomiting, seizures. Some had other, unspecified complications.

The Bill does not attempt to address the issue of a botched assisted death, where a patient does not die from the substances provided.

There are deep ethical questions involved with doctors’ response to this. Are medical professionals to intervene and ensure death, thereby participating in active euthanasia? Or are they to attempt to reverse the process? It is alarming that this very significant problem has not been addressed in the bill and is intended to be left to guidance.

(1) https://www.dignityindying.org.uk/assisted-dying/our-position/

(2)
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9270985/#:~:text=Drugs%20used%20for%20medical%20purposes,lethal%20drugs%20is%20largely%20unknown.

(3) https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year25.pdf

Question 5 - Health professionals

Which of the following most closely matches your opinion on how the Bill may affect the medical profession? Tick all that apply.

Other – please provide further details in the text box (200 characters max)

If you selected Other, please provide your answer in the text box below:

We would agree with points one and four.

Space for further comment on your answer:

It is notable that palliative doctors – who support people in their final chapter of life – are strongly opposed to assisted suicide when asked about the issue (1).

A survey of Scottish palliative doctors by the Association for Palliative Medicine found that 8 in 10 doctors think assisted suicide would negatively impact the doctor/patient relationship. More than 4 in 10 also indicated that they would resign if the law changes and their organisations were required to participate in assisted deaths. The resultant impact on the profession of doctor resignations would undermine the quality of healthcare enjoyed by all patients.

A “good death” can be assured through expert-led, well-resourced palliative care. It cannot be assured through assisted suicide, which is medically dangerous, results in harrowing complications, and can take hours and even days.

On the issue of conscientious objection, we would draw attention to the concerns of Dr Mary Neal, reader in law at Strathclyde University. She states (2) that: “Holyrood cannot legislate for conscience rights without express authority from Westminster. Without such authority, any such clause is quite simply ineffective.”

And she cautions that the burden of proof regarding conscientious objection is left to medical professionals: “...professionals who conscientiously object to assisted dying might find themselves challenged to prove in court on a balance of probabilities that they have an objection, or that their objection is truly ‘conscientious’. Doing so is likely to be practically impossible”.

She adds that there is “a question mark over the bill’s competence on the basis that section 18 may not be compliant with the Human Rights Act”.

(1) https://apmonline.org/wp-content/uploads/2023/02/APM-Survey-of-AD-Impact-on-PC-FINAL.pdf

(2) https://www.scottishlegal.com/articles/mary-neal-protection-for-conscience-in-the-assisted-dying-bill-a-wing-and-a-prayer-or-smoke-and-mirrors

Question 6 - Death certification

Which of the following most closely matches your opinion on recording the cause of death?

I do not support this approach because it is important that the cause of death information is recorded accurately

If you selected Other, please provide your answer in the text box below:

Space for further comment on your answer:

Section 17 states that: "the terminal illness involved is to be recorded as the disease or condition directly leading to their death (rather than the approved substance provided to them by virtue of section 15)". In suggesting this recording process, the bill architects are proposing a legal fiction that will directly impact data recording in Scotland with regard to healthcare outcomes, and suicides.

Our medical allies are clear that a person's decision to prematurely end their life by administering a lethal substance is suicide, and doctors' facilitation of this process is assisted suicide. They caution that the proposals before MSPs will impact wider suicide prevention efforts. A previous Assisted Suicide Bill at the Scottish Parliament was more intellectually honest, and legally accurate, than the current bill.

Question 7 – Reporting and review requirements

Which of the following most closely matches your opinion on the reporting and review requirements set out in the Bill?

The reporting and review requirements should be extended to increase transparency

If you selected Other, please provide your answer in the text box below:

Space for further comment on your answer:

We are concerned that the limited data recording proposed by the bill would obscure problems associated with assisted deaths if agreed as drafted. Section 24 stipulates that Ministers must be provided with limited information on assisted deaths but not the duration of deaths or complications that occurred prior to death. Thorough data recording is essential for robust scrutiny.

Question 8 – Any other comments on the Bill

Do you have any other comments in relation to the Bill?

Please use this textbox to provide your answer:

We wish to provide an additional comment on the issues of suicide prevention; disability; poverty; and a better way for Scotland. We also wish to provide expanded comments on questions 1 to 7.

One: Additional comment on suicide prevention; disability; poverty, a better way:

Suicide prevention:

A major consideration in this debate, and one that is often overlooked, is the potential impact of a law change on wider suicide prevention efforts. Allan House, emeritus professor of liaison psychiatry, is an expert on the overlap between physical and mental health, especially in people with severe physical illness. He comments:

"There is a wider risk to society when you legislate the idea that certain suicides are to be supported – in other words that there are some people whose lives are not worth living who should be helped to end their lives. That's a more intangible risk, but it feels to me like the greater risk long term.

"As things stand, we have a national suicide prevention strategy, based on the idea that all suicides should be something we work to prevent. If we say 'now there are some suicides that we actually support and assist' this will change societal attitudes in profound ways. It seems to me this would reduce the drive to prevent suicide. Instead of assisting suicide in people who think their lives are intolerable, we should be working to stop it being the case that people with severe physical illnesses find their lives intolerable."

Professor House also emphasises a complex web of issues that underpin suicidal ideation. He believes no proposed system of 'safeguards' would be able to fully account for and mitigate such issues under a Scottish assisted suicide law:

"We know from suicide statistics that people at risk very often have no social support in their lives. They are living on their own or feel lonely. They may have other personal problems with recurrent spells of depression, for example. These vulnerabilities tend to get neglected in debates. People talk about mental capacity, or the individual's right to choose but what we really need to know more about is the social context that drives people to suicidal thinking."

Disability:

Leading opponents of assisted suicide and euthanasia in Scotland and around the globe include members of the disabled people's community. Dr Miro Griffiths, our campaign lead, and an expert advisor on disability, believes that legalising the practice will significantly impact disabled people. Dr Griffiths comments:

"As a disabled person who is permanently struggling to have their needs met and be valued, and as a sociologist who questions how and why we organise

societies, my feeling is that many people will opt for assisted suicide on the basis that they are fed up with the struggles they are experiencing. People will be so desperate to remove the injustices they face they will choose this option of death and to me that's not a good rationale for having such a system."

"Assisted suicide will fundamentally change the way we understand life and death for marginalised communities, including disabled people. People are struggling on a daily basis to access sufficient support. Because of this, there can never be a safeguard that's effective enough. If you don't have accessible and inclusive societies, why would you even be contemplating the idea of marginalised communities being exposed to assisted suicide?"

Dr Griffiths highlights existing, negative value judgments that arise within healthcare and how they will affect decision-making under an 'assisted dying' law:

"When I've gone to hospital, usually because my respiratory is declining, the question often asked to my partner, or to a family member, or even my personal assistants, is 'should we place a do not resuscitate notice on Miro's notes?' Straight away the conversation is built upon the premise of 'is this life worth saving?' I know my life and the value placed on it is questioned. If you introduce a mechanism of assisted suicide you're effectively saying, 'we'll still debate whether your life is worth saving but we're also always going to have this option on the table now where your life can be ended'. This is increasing the levels of anxiety felt by myself and also others in my community."

We would also draw the Committee's attention to the following statements by disabled people's organisations and disabled people:

Not Dead Yet UK: "We believe that legalising assisted suicide will inevitably lead to increasingly adverse judgements about the quality of life of disabled people. This will undoubtedly begin to affect the many disabled people who cannot speak for themselves and who have not requested death" (1).

US National Council on Disability: "NCD's concerns...stem from the understanding that if assisted suicide is legal, some people's lives, particularly those of people with disabilities, will be ended without their fully informed and free consent, through mistakes, abuses, insufficient knowledge, and the unjust lack of better options. No safeguards have ever been enacted or proposed that can prevent this outcome" (2).

UN Human Rights Special Rapporteurs, 2021: "We all accept that it could never be a well-reasoned decision for a person belonging to any other protected group - be it a racial minority, gender or sexual minorities - to end their lives because they experience suffering on account of their status... Disability should never be a ground or justification to end someone's life directly or indirectly" (3).

Poverty:

People experiencing poverty face various inequalities that place them at particular risk of injustice under an assisted suicide law. This important issue must not be overlooked.

Psychiatrist Professor Allan House states: "There are some very long-standing studies showing that access to primary care is affected by poverty. People in deprived areas have less access to a GP. GPs in poorer areas have bigger lists and see patients less often than GPs in affluent areas. Social inequality is matched by health inequality. How people access 'assisted dying' would be influenced by these factors."

Cancer is one of the most-common serious illnesses affecting Scots. A report on the relationship between deprivation and cancer, published by Cancer Research UK (4), found that people living in more deprived areas in Scotland are more likely to get cancer and are 74% more likely to die from the disease than people in the least deprived areas. People in deprived areas are more likely to be diagnosed with cancer at advanced stages, given reduced awareness of symptoms, and lower attendance of screenings.

Research also indicates that people experiencing socioeconomic deprivation in Scotland have decreased access to palliative care services (5). And adults living in the most deprived areas of the country are twice as likely to experience mental health issues such as depression (6).

We believe an assisted suicide framework would compound existing social inequalities, and single out the poorest in society for unjust treatment. People facing poverty may opt for an assisted as they lack the support to live. Ellen Clifford, of the organisation Disabled People Against Cuts, has also warned of this risk:

"Following the introduction of the welfare state, suicides dramatically reduced in cases of poverty. The legalisation of assisted suicide threatens to bring back conditions whereby a person's decision to end their own life as a consequence of social disadvantage is seen as a matter of personal choice rather than one of social injustice" (7).

A better way:

As a campaign, we believe that assisted suicide would be a dangerous and regressive path for our society. But we acknowledge that keeping the door closed to this practice is not enough. Our society needs to outline a better path for people with terminal illnesses, and other groups involved in this debate. We asked three of our expert allies to summarise their vision.

Dr Juliet Spiller said: "We need to ensure that every person living with a terminal diagnosis has access to all the support they need. That they are able to plan ahead, to identify what really matters to them, the treatments they want, the treatments they want to refuse. They need to be able to express their preferences and have conversations with healthcare professionals. Everyone needs to be on the same page and speaking from the same set of values. The amount of political attention and resources dedicated to end-of-life care at present is miniscule compared to other areas of medicine and clinical practice. We need a much bigger focus on how we ensure everyone in Scotland has equitable access to excellent palliative care."

Dr Miro Griffiths said: "For me, the better way forward is building a truly accessible, inclusive, and participatory society. Assisted suicide is incompatible with this aim. We need to remove it from the discussion and instead focus on what appropriate palliative care looks like. How do we make it well-resourced and available to all people as their health needs change? We need to ask what kind of health service we want and work to ensure people

don't feel ashamed or stigmatised because of how their bodies function. Once we have realised an accessible and inclusive and participatory society, my assumption would be that we'll no longer need to debate the idea of assisted suicide."

Professor Allan House said: "A better way forward for our society involves more imaginative thinking about how to address the mental health impacts of living with a severe physical illness. We have to understand how social context influences people's thoughts about their own lives – for example their thoughts about living with a disability. And we have to join up our services. No doubt, services are better than they were decades ago, but we still have a long way to go in delivering high quality services to everybody living with a disability or severe physical illness who is moving towards the end of life. The best services are models of what every service should be."

(1) https://notdeadyetuk.org/about/

(2) https://www.ncd.gov/report/the-danger-of-assisted-suicide-laws/

(3) https://www.ohchr.org/en/press-releases/2021/01/disability-not-reason-sanction-medically-assisted-dying-un-experts

(4) https://news.cancerresearchuk.org/2022/11/28/cancer-research-uk-report-highlights-stark-cancer-inequalities-across-scotland/

(5)
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9636719/#:~:text=Those%20experiencing%20socioeconomic%20deprivation%20have,with%20patients%20from%2

(6)
https://www.povertyalliance.org/tackling-poverty-for-good-mental-health/#:~:text=Studies%20suggest%2C%20compared%20to%20those,have%20a%20drug%2Dr

(7)
https://morningstaronline.co.uk/article/why-starmer-dead-wrong-about-assisted-dying#:~:text=The%20PBO%20expected%20amending%20the,commit%20to%20i

Two: Expanded answers to consultation questions:

Question 1

Impact on healthcare professionals:

Campaigners assert that assisted suicide can be introduced alongside existing end-of-life care without issue. However, our doctor allies believe it would have a hugely negative impact. They highlight research evidence on the effects of assisted suicide and euthanasia laws on palliative medicine access, hospice funding, and physicians (1).

Dr Juliet Spiller has worked as a consultant in palliative medicine since 2002 in hospice, hospital and community settings providing support for patients with terminal illness and their families. Dr Spiller contests the idea that palliative care is not sufficient to deal with the mental, physical, relational, and existential issues arising from terminal illness.

She has said: "The idea that you can focus on providing access to assisted suicide and providing access to palliative care is misguided. You can't do both.

"There's no question that an 'assisted dying' law would very negatively impact wider access to palliative care. I think one of my biggest worries is that if you catch people in a bad period, and you hear that expression of 'I wish I was dead' and you act on that, the opportunity for any further value of life is gone. As soon as you hook into that expression of suffering, and respond to it with an offer of death, that is immediately a destructive thing.

"I have been working in palliative care for twenty years and in this time, I have seen so many people come through crisis and despair to an end of life that included so many amazing things. I've seen families come together, I've seen conversations happen that would never have happened in any other situation, I've seen amazing memories created, I've seen families working through hard times. It brings people together. I would hate for any individual to miss out on these opportunities."

Survey data shows that a significant majority of doctors who work with patients at the end of life oppose assisted suicide. A 2022 survey of Scottish palliative doctors by the Association for Palliative Medicine of Great Britain and Ireland (2) found that:

75% of doctors would not be willing to participate in any part of an 'assisted dying' process. 43% would resign if their organisation elected to take part in assisted suicides. 71% would consider resigning if their organisation elected to take part in assisted suicides.

In addition: 86% of respondents said the practice would have a negative or very negative impact on palliative care services. 78% said assisted suicide would have a negative or very negative impact on their conversations with patients and families. 88% said they do not believe that proposed legal safeguards would prevent harm to vulnerable patients under their care.

Impact on doctor/patient relationship:

We would stress that the provision of lethal drugs to patients represents a fundamental ethical shift that would impact the relationship between doctors and patients. Trust between a patient and their doctor would be under threat, as would the relationship between doctors and patients' wider family. The psychological impact on medical professionals of assisting a person to end their own life must also be considered and has not been properly assessed to date.

Coercion and pressure:

Pressure to opt for an 'assisted death' will come from numerous sources. Proponents argue that safeguards can ensure that overt forms of coercion are spotted. We do not believe this is possible, given doctors' inability to screen patients properly for this issue. Coercion takes various forms and can be very subtle. In any case, other, less overt, pressures would come into play when a person is considering the option of assisted death.

Ultimately, patients' decisions would be influenced, unjustly, by their socio-economic status, access to specialist care, and experience of various hardships such as loneliness, addiction, homelessness, relationship breakdown, and past trauma. Some patients may also feel that they are a burden on loved ones, or wider society. Others may feel that they should opt to end their lives in order to ensure that their inheritance is not spent on paying for care.

Mission creep:

Both countries that have long-standing assisted suicide or euthanasia laws and countries that have introduced laws in the last decade have witnessed significant expansion.

Canada only legalised euthanasia in 2016 but has already scrapped the requirement for a person to be terminally ill and has now extended it to those with mental illness (3).

In Belgium, the 2002 law on euthanasia was initially confined to adults. This was extended in 2014 to children and is now applied to people with Alzheimer's and depression (4).

In the Netherlands, the key criterion of "unbearable suffering" is broadly understood. Cases have involved people with psychiatric disorders and people who were not seriously ill (5).

In the US state of California, assisted deaths have climbed significantly after a mandatory waiting period was cut by 13 days (6).

In other contexts, we are witnessing constant pressure to expand legislation. This includes more recent laws frequently cited by 'assisted dying' campaigners.

In the Australian Capital Territory (ACT), legislators are considering removing a "time frame to death" requirement, as "estimating life expectancy is inherently uncertain" (7).

Doctors in the Australian state of Victoria threatened legal action if rules preventing less-rigorous assisted suicide consultations on the phone and via Zoom aren't changed (8).

And the architect of New Zealand's 'assisted dying' law is challenging a rule limiting access to those with six months to live - despite promises that legislation would be strictly limited (9).

If the legislation proposed in Scotland is passed, it is inevitable that its eligibility criteria, and safeguarding mechanisms would be challenged in parliament and through the courts. Individuals who want to be eligible for assisted death would claim unlawful discrimination. Others may attack rules they consider to be over-strict.

Campaigning organisations in the UK already support a wider law and see a law defined around terminal illness as the first, incremental step on a road to permissive legislation. No politician today can rule out a permissive law in Scotland in years to come – unless assisted suicide legislation does not reach the statue book in the first place.

Question 2

'Terminal illness':

The definition of terminal illness in the Bill - an "advanced", "progressive" condition that a patient is "unable to recover" from, which is expected to cause their "premature death" – is very broad. At present, it could catch patients suffering from anorexia, and some disabilities.

The bill also creates confusion on whether a person with dementia is eligible. On one hand, dementia is a progressive, incurable condition that causes a person to die prematurely. This should make people with the condition eligible. On the other hand, it is intended that persons with a mental disorder should be excluded. This contradiction is not addressed.

The requirement in Section 3 that a person should be "ordinarily resident" in Scotland for at least 12 months raises the spectre of 'suicide tourism', whereby persons with terminal illness in other parts of the UK make their home in Scotland in order to access assisted suicide. This would compound pressures on NHS Scotland and impact ethically divergent patient care in England, Wales, and NI.

Minimum age:

It's concerning that 16-year-old children are deemed eligible. The Scottish Partnership for Palliative Care has said: "In young people the age of legal mental capacity to give consent should not be assumed to be the same as the age at which an individual achieves the cognitive and emotional ability to make a particular decision".

Question 3

The safety of patients is paramount. Proponents of assisted suicide argue that safeguards can be constructed in order to avoid negative consequences.

Our expert supporters reject this claim outright, and stress that it is impossible to guard against abuses or rule out future legislative expansion. Psychiatrist Professor Allan House states:

“We know that there is no human system that works without fail. It doesn’t matter if it is manned space flight, or running a nuclear power station, or high-risk interventions in ill children where the stakes are extremely high. We know that errors happen. So, somebody who’s prepared to say a system can work without fail is either intentionally or unintentionally not looking at where the sources of failure or error might be.”

Dr Juliet Spiller states: “In healthcare at the moment there are countless examples of well-intentioned policies put in place that have been misused, abused, or misunderstood – where poor practice has resulted, and safeguards have been lost or overlooked. That will happen with assisted suicide legislation. Safeguards will be swept aside…It is simply not possible to safeguard so robustly that people don’t fall prey to abuse, or misapplication, or misunderstanding”.

Examination by two doctors:

It is notable that the assessments to be undertaken by the coordinating medical practitioner, and the independent registered medical practitioner do not include any consideration of the patient’s wider circumstances, including their social status, family situation, access to support etc.

The involvement of a second “independent registered medical practitioner” – Section 6 (3) and (6) – is presented as an additional safeguard in patient assessments. The fact that this individual must not have “provided any treatment or care for the person being assessed” means it could be seen as the opposite. This professional’s lack of involvement with a patient means they are less likely to know of information in their medical history, or wider circumstances, that may be a cause for concern.

Section 7 (a) (i) specifies that medical practitioners should consider an applicant’s “diagnosis and prognosis”. It’s important to stress that doctors’ opinions are fallible, and not infrequently wrong. Patients who are told that they have a few months to live sometimes live much longer. A wrong opinion may cause a person to opt for ‘assisted death’ when they might not have done so with accurate information.

Test of non-coercion:

Sections 6, 8 and 15 specify that medical practitioners must ensure that a patient requested assisted suicide “voluntarily and has not been coerced or pressured by any other person”. We would submit that doctors are wholly unprepared to make this judgment, given that coercion can be subtle and hard to detect. Such assessments are inherently fallible and cannot be considered a ‘safeguard’.

It should also be noted that there is no provision for assessment of pressures arising from a patient’s background or wider circumstances. As we have warned, a person’s decision to opt for assisted death will be affected by their experience of healthcare inequality, loneliness, poverty, family breakdown, addiction, and a host of other potential factors. People would inevitably opt to die because they lack sufficient support to live. MSPs should reflect on whether this is a just and progressive outcome.

Period of reflection:

The suggested reflection period of 14 days (Section 9) – or 48 hours if a person’s death is thought to be imminent – is alarming and should not be considered a safeguard. Both psychiatrists and palliative doctors stress the potential for patients to adjust their outlook over a longer period, especially if new or additional forms of support become available. The two-week period diminishes patient choice.

Question 4

Method of dying:

People on both sides of the debate want to help those facing the trauma of terminal illness. The question is how such people are best supported. Campaigners for assisted suicide believe it should be an option and describe it as a “safe and comfortable death” (10).

It is notable that proponents avoid discussing the specifics of what the assisted death process involves. The claim that assisted deaths are “safe” and “comfortable” must be assessed and our allies – expert medics in relevant fields – reject this characterisation.

Palliative care doctor Juliet Spiller has said: “The evidence base is really non-existent in terms of what works. Some people take oral medication and they do die within an hour. Some people take the same oral medication, and it is days. Sometimes it doesn’t work. Sometimes they might be sick. Sometimes they might have a seizure. Sometimes they might become very agitated and distressed because of the impact of the oral medication on them. There is no way to make this safe”.

Anaesthesiologist Dr Joel Zivot has said: “Laws in Oregon, like those proposed in the UK, require patients to take the drugs themselves, which rules out any form of general anaesthetic. Often patients are handed anti-sickness and anti-seizure tablets but nothing more in preparation, meaning they’re very much awake as the assisted suici [answer truncated to 25000 characters]