ASSISTED DYING FOR TERMINALLY ILL ADULTS (SCOTLAND) BILL – COMMITTEE CALL FOR VIEWS – BISHOPS' CONFERENCE OF SCOTLAND RESPONSE

Question 1 – Overarching question

The purpose of the Assisted Dying for Terminally Ill Adults (Scotland) Bill is to introduce a lawful form of assisted dying for people over the age of 16 with a terminal illness.

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

Fully support

Partially support

Neutral/Don't know

Partially oppose

Strongly oppose

Which of the following factors are most important to you when considering the issue of assisted dying? (Select up to 3)

Impact on healthcare professionals and the doctor/patient relationship

Personal autonomy

Personal dignity

Reducing suffering

Risk of coercion of vulnerable people - 3

Risk of devaluing lives of vulnerable groups - 2

Sanctity of life - 1

Risk of eligibility being broadened and safeguards reduced over time

Other, please specify

Undermines efforts to provide good palliative care

Palliative medicine constitutes a precious and crucial instrument in the care of patients during the most painful, agonising, chronic and terminal stages of illness. Palliative care is an authentic expression of the human activity of providing care, the tangible symbol of the compassionate remaining at the side of the suffering person. Its goal is to alleviate suffering in the final stages of

illness and at the same time to ensure the patient appropriate human accompaniment improving quality of life and overall wellbeing as much as possible and in a dignified manner.[1]

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

Next to the family, hospices which welcome the terminally sick and ensure their care until the last moment of life provide an important and valuable service. These centres are an example of genuine humanity in society, sanctuaries where suffering is full of meaning.[2]

The Assisted Dying for Terminally Ill Adults (Scotland) Bill threatens the provision of palliative care services in Scotland. The proposal, to be blunt, provides a quick, cheap alternative to good palliative care. This is supported by claims in Mr McArthur's proposal for a Bill, which chillingly conceded that it is cheaper to end life than to provide care.[3] The focus must be on providing care, not providing a cheap death.

If this Bill is passed and assisted suicide becomes legal, doctors and other health professionals will be under pressure to make value judgements about providing costly care or recommending assisted suicide which is cheaper. The NHS in Scotland is under extreme pressure and in urgent need of investment, including in the provision of palliative care. Marie Curie estimates 25% of people who die in the UK do so without receiving the palliative care they need.[4]

Furthermore, legalising assisted suicide could become a disincentive for people entering palliative medicine and cause others to leave the profession. A 2022 survey of palliative medicine doctors in Scotland found that 75% would not be willing to participate in any part of the assisted suicide process, and 43% would resign if their organisation offered assisted suicide.[5]

Undermines efforts to prevent suicide

Suicide prevention efforts rightly affirm that everyone's life matters; that every life has value. However, the legalisation of assisted suicide suggests something very different; it suggests that sometimes suicide *is* an appropriate response to an individual's circumstances, worries and anxieties. We must ask ourselves the question: what future for suicide prevention programmes in a Scotland where suicide is supported by the state?

There is no evidence that legalisation of assisted suicide and/or euthanasia would have a beneficial effect on suicide prevention. In fact, there is robust evidence that the total number of self-initiated deaths rises significantly where assisted suicide and/or euthanasia is available, and

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[1] Samaritanus bonus, letter on the care of persons in the critical and terminal phase of life, Congregation for the Doctrine of the Faith Letter Samaritanus bonus on the care of persons in the critical and terminal phases of life (14 July 2020) (vatican.va)

[2] ibid

[3] footnote 124, page 28 of the 2021 consultation document 'Assisted Dying for Terminally Ill Adults (Scotland) Bill', Assisted Dying Consultation 2021 - FINAL (parliament.scot)

[4] More than one person every minute will die with palliative care needs, Marie Curie More than one person every minute will die with palliative care needs (mariecurie.org.uk)

[5] Survey of Scottish Palliative Care Doctors. Association for Palliative Medicine Microsoft Word - APM Survey of AD- Impact on PC FINAL 26Jan23 All comments incorporated (3) (apmonline.org)

strong evidence that this has an impact on older women. There is also some evidence that deaths by non-assisted means also increases. There is no evidence of a reduction in non-assisted suicide.[6]

Instead of suicide prevention, state assisted suicide promotes suicide completion. The current law helps prevent suicide and should be retained.

Risk of coercion of vulnerable people

In Oregon, consistently around half of patients list being a burden as a reason to end their lives. This suggests that society is failing those most in need of help and support, resulting in vulnerable people, including the elderly and disabled, feeling pressure to end their lives to lessen the impact on family, friends, carers, and the state. In such situations the option of assisted suicide becomes less about having a 'right' to die and more about feeling the full weight and expectation of a 'duty' to die.

When the elderly and disabled express concerns about being a burden, the appropriate response is not to suggest that they have a duty to die; rather, it is to commit to meeting their needs and providing the care and compassion to help them live. If Scotland establishes the provision of death on demand and this becomes normal practice, how will that not become a cultural expectation for the vulnerable, including the elderly, disabled, and lonely?

The Glasgow Disability Alliance (GDA) has said that the proposal to legalise assisted suicide would send a message to disabled people that they are a burden and, thus, put pressure on disabled people to make the choice to die. Speaking in early 2023, CEO of GDA, Tressa Burke, said that the legislation could not offer enough protections "to stop disabled people being pressured into assisted dying when no health, social care or other support is available." Ms Burke said: "I have attended far too many funerals of GDA members who have died prematurely because of poverty and inequalities, including some who have taken their own lives because of state failures to support disabled people." Ms Burke concluded that disabled people would "hear a message that we are a burden and feel a pressure to make the 'choice' to die."[7]

Furthermore, one cannot ignore the deeply troubling prevalence of elder abuse in society. It is estimated that such abuse – which may take the form of physical, psychological and emotional, sexual, financial abuse and neglect – affects one in six older people in the UK.[8] If an elderly person is being subjected to abuse by those closest to them, it would not be surprising if the resultant misery drove them to consider assisted suicide.

In Canada the poor and vulnerable are being offered an assisted death instead of social care. Canadian Federal Minister for Disability Inclusion, Carla Qualtrough, has said: "In some places in our country, it's easier to access MAiD [Medical Assistance in Dying] than it is to get a wheelchair." In one deeply troubling case, Veteran and celebrated Paralympian Christine

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[6] Suicide Prevention: does legalising assisted suicide make things better or worse? Professor David Albert Jones, 2022, Professor of Bioethics and Director of the Anscombe Bioethics Centre, Oxford Suicide Prevention: Does Legalising Assisted Suicide Make Things Better Or Worse? (Professor David Albert Jones) | Anscombe Bioethics

[7] Glasgow Disability Alliance Fears Over Assisted Dying, The Herald, 11th September 2023 Glasgow Disability Alliance fears over assisted dying | The Herald (heraldscotland.com)

[8] Hourglass Scotland Welcome to Hourglass Scotland | Hourglass (wearehourglass.scot)

Gauthier had been trying to get a wheelchair lift installed in her home but was offered an assisted death instead.[9]

A 2023 poll in Canada revealed that more than a quarter of Canadians support euthanasia on the grounds of poverty. The same poll also revealed that a similar number of people support euthanasia on the grounds of homelessness, 43% support it for mental illness, and 50% support euthanasia for disabled people. These deeply disturbing results suggest that, when assisted suicide and/or euthanasia is legalised, there is a drive from some sections of society to extend the scope of legislation which could, in turn, lead to unbearable social pressure on vulnerable people to end their lives prematurely.[10]

In 2022, in Washington State, US, the legislature commissioned a study of 'barriers' to 'access' to the Death with Dignity Act, and End of Life Washington surveyed patients and caregivers. The results revealed that caregivers were two to four times more likely to complain of "barriers" than the patients whose interests they allegedly serve: 47 percent of caregivers agreed that barriers include a healthcare facility's unwillingness to participate (compared to 16 percent of patients); 63 percent cited the patient's doctor being unwilling to prescribe the drugs (compared to 32 percent); and 21 percent complained about the waiting period giving a patient time to reconsider (compared to 5 percent). That year, the health department reported that 59 percent of patients request the drugs because they feel they are a "burden" to family or caregivers.[11]

Risk of eligibility being broadened and safeguards being eroded over time

No matter how well intentioned the safeguards are, it is impossible for any government to draft assisted suicide laws which include legal protection from future expansion of those laws. A law permitting assisted suicide will quickly become a runaway train.

Canada has eroded safeguards in just five years: expanding from terminal illness to include chronic illness and disability; removing the ten-day period for reflection; and waiving the requirement for final consent. A person with anorexia may qualify for Medical Assistance in Dying if they refuse treatment and their death is considered 'reasonably foreseeable' owing to malnourishment.[12] In 2022, the number of people who ended their lives by assisted suicide and euthanasia accounted for 4.1% of all deaths in Canada; a total of 13,241 people.[13]

In Oregon, USA, in 2017, the Oregon Health Division revealed that the criterion of 'terminal' illness is met if the patient would die in less than six months without treatment, regardless of how long he or she would live with treatment. This helps explain why, in recent years, qualifying conditions

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[9] Canadian Paralympian: I asked for a disability ramp – and was offered euthanasia, The Telegraph, 2nd September 2023 Canadian Paralympian: I asked for a disability ramp - and was offered euthanasia (telegraph.co.uk)

[10] Poll conducted by Research Co. on Medical Assistance in Dying in Canada, 5th May 2023 Tables_MAiD_CAN_05May2023.xlsx - Group (researchco.ca)

[11] Assisted Death and The Economist, Richard M Doerflinger, 24th July 2024 Assisted Death and The Economist - Public Discourse (thepublicdiscourse.com)

[12] Care Not Killing Scotland Future Impacts – Care Not Killing Scotland

[13] Fourth annual report on medical assistance in dying Canada 2022 Fourth annual report on Medical Assistance in Dying in Canada 2022 - Canada.ca

have included arthritis, diabetes, anorexia (a psychiatric condition), "benign or uncertain" tumors, "medical care complications," and "other" or "unknown."[14]

In the Netherlands, eligibility has been expanded from permitting euthanasia of people who are terminally ill to euthanasia of those who are chronically ill and from physical illness to mental illness.

In 2023 it was reported that several people with autism and intellectual disabilities had been legally euthanised in recent years in the Netherlands because they said they could not lead normal lives. The cases included five people younger than 30 who cited autism as either the only reason or a major contributing factor for euthanasia.[15]

Dutch law now permits children under 1 year old with disabilities like Spina Bifida to be euthanised with parental consent.[16] There are also plans to extend eligibility to terminally ill children between 1 and 12 years old.[17] In Belgium, children have been eligible for a doctor-assisted death since 2014.

In the Netherlands, the number of deaths by euthanasia or assisted suicide rose nearly 14% in 2022, to a total of 8,720, including 288 people with dementia and 115 people with psychiatric disorders.[18]

The move to include mental illness is deeply concerning as it is not possible for doctors to accurately determine medical futility; that is, to decide that a given psychiatric condition is irremediable, and that there is therefore no prospect of recovery or therapeutic improvement of any kind. Therefore, it is essentially impossible to describe any psychiatric illness as incurable.

Once a law permitting assisted suicide and/or euthanasia is established, so-called safeguards will be eroded and eligibility criteria expanded to create a system of death on demand and death by prescription, facilitated by the state. As evidenced in other jurisdictions, it is a runaway train and, once started, it cannot be stopped.

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[14] Assisted Death and The Economist, Richard M Doerflinger, 24th July 2024 Assisted Death and The Economist - Public Discourse (thepublicdiscourse.com)

[15] Euthanasia and physician-assisted suicide in people with intellectual disabilities and/or autism spectrum disorders: investigation of 39 Dutch case reports (2012–2021) by Tuffrey-Wijne, Curfs, Hollins and Finlay S2056472423000698jra 1..8 (nih.gov)

[16] Our Duty of Care – against euthanasia and assisted suicide About – Our Duty of Care against euthanasia & assisted suicide

[17] Netherlands to broaden euthanasia rules to cover children of all ages, Guardian, 14th April 2023 Netherlands to broaden euthanasia rules to cover children of all ages | Assisted dying | The Guardian

[18] Regional Euthanasia Review Committees Annual Report 2022 Annual reports (English, Spanish, French and German) | Annual report | Regional Euthanasia Review Committees (euthanasiecommissie.nl)

Question 2 – Eligibility

The Bill proposes that assisted dying would be available only to terminally ill adults.

The Bill defines someone as terminally ill if they 'have an advanced and progressive disease, illness or condition from which they are unable to recover and that can reasonably be expected to cause their premature death'.

An adult is defined as someone aged 16 or over. To be eligible a person would also need to have been resident in Scotland for at least 12 months and be registered with a GP practice.

Eligibility – Terminal illness

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

Assisted dying should be available only to people who are terminally ill, and the definition of terminal illness should be narrower than in the Bill

Assisted dying should be available only to people who are terminally ill, and the definition of terminal illness in the Bill is about right

Assisted dying should be available only to people who are terminally ill, but the definition of terminal illness should be broader than in the Bill

Assisted dying should be available to people who are terminally ill, and to people in some other categories.

Other – please provide further detail

If you have further comments, please provide these

The Bill deems a person to be terminally ill if they have "an advanced and progressive disease, illness or condition from which they are unable to recover and that can reasonably be expected to cause their premature death."

This definition raises significant questions. Firstly, it is known to be extremely challenging for doctors to provide an accurate prognosis, as evidenced in a systematic review by White, Reid, Harris et al, which reached the conclusion that "clinicians' predictions are frequently inaccurate".[19]

The terms 'advanced' and 'progressive' widens the scope of the definition to include diseases such as diabetes. There is little doubt that diabetes could be considered 'advanced' and 'progressive', and complications from diabetes can also arise which, although they may not be immediately life threatening, could shorten life. Moreover, the absence of a specified life

[19] White N, Reid F, Harris A, et al. A systematic review of predictions of survival in palliative care: how accurate are clinicians and who are the experts? Plos One 2016; 11(8): e0161407) A Systematic Review of Predictions of Survival in Palliative Care: How Accurate Are Clinicians and Who Are the Experts? | PLOS ONE

expectancy in order to be eligible for an assisted death will mean that people who could go on to live for many years would have their lives ended prematurely.

Anorexia would also be covered under the Bill according to Professor David Albert Jones, professor of bioethics at St Mary's University, London.[20]

And Professor June Andrews, an expert in the care of people with dementia and older frail people, has said that the definition of terminal illness in the Bill would include dementia and, despite the Bill excluding people with mental illness from being eligible for an assisted death, it would be "impossible" to uphold such a restriction once the law is passed.[21]

Furthermore, most countries where assisted suicide and/or euthanasia is legal safeguards have been eroded and/or eligibility criteria expanded.

Eligibility – minimum age

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.

The minimum age should be lower than 16

The minimum age should be 16

The minimum age should be 18

The minimum age should be higher than 18

Other – please provide further detail

If you have further comments, please provide these

[20] 16-year-olds who have anorexia could be granted right to die, experts warn. Daily Mail, 20th April 2024 16-year-olds who have anorexia could be granted right to die, experts warn | Daily Mail Online

[21] The shocking case of dementia patient who was euthanised despite changing her mind, Professor June Andrews, The Scotsman, 25th July 2024 The shocking case of dementia patient who was euthanised despite changing her mind (scotsman.com)

Question 3 – The Assisted Dying procedure and procedural safeguards

The Bill describes the procedure which would be in place for those wishing to have an assisted death.

It sets out various procedural safeguards, including:

examination by two doctors

test of capacity

test of non-coercion

two-stage process with period for reflection

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

I do not agree with the procedure and procedural safeguards because I oppose assisted dying in principle

The procedure should be strengthened to protect against abuse

The procedure strikes an appropriate balance

The procedure should be simplified to minimise delay and distress to those seeking an assisted death

Other – please provide further detail

If you have further comments, please provide these

It is telling that in most countries where assisted suicide and/or euthanasia is legal safeguards have been eroded and/or eligibility criteria expanded.

The Bill requires an assessment to be carried out by a medical practitioner to ensure the patient who requests an assisted death is doing so voluntarily and has not been coerced or pressured by any other person into making it. It is impossible to guarantee that any and all forms of coercion can be identified in this way. The only way to ensure the absence of coercion is to retain the current law and not pass this Bill.

It is remarkable that there is nothing in the Bill which requires the patient to consult with an expert in palliative care. How informed can the patient be in making a decision about assisted suicide when they have not received expert advice on the potential benefits of palliative care?

The conscience provisions in the Bill are unclear, meaning that doctors who would not want to take part in ending the lives of patients cannot rely on assurances that they would be able to opt out.[22]

[22] Assisted dying: why Scotland should be wary of changing the law, Dr Mary Neal, The Conversation, 7th May 2024 Assisted dying: why Scotland should be wary of changing the law (theconversation.com)

The Bill's accompanying documentation admits that the provisions in the Bill relating to regulated medicines and controlled drugs is a reserved matter for UK Ministers and that Scottish Government Ministers do not have the required powers to legislate in this area.[23]

[23] Para 8, Policy Memorandum, Assisted Dying for Terminally Ill Adults (Scotland) Bill Introduced | Scottish Parliament Website

Question 4 – Method of dying

The Bill authorises a medical practitioner or authorised health professional to provide an eligible adult who meets certain conditions with a substance with which the adult can end their own life.

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.

It should become lawful to supply people with a substance for the purpose of ending their own life, as proposed in the Bill

It should become lawful to supply people with a substance for the purpose of ending their own life, as proposed in the Bill, and it should also be possible for someone else to administer the substance to the adult, where the adult is unable to self-administer.

Other – please provide further detail

If you have further comments, please provide these

In a letter to the Economist on 27th November 2021, Dr Claud Regnard, Consultant in Palliative Medicine; Amy Proffitt, President of the Association for Palliative Medicine; and Rob George, Professor of Palliative Care, stated that there is no useful data on drug safety regarding drugs used for assisted suicide and warned that 'doctors will be expected to prescribe untested drugs'.[24]

Dr Joel Zivot, associate professor of anaesthiology and surgery, wrote the following in The Spectator: "I am quite certain that assisted suicide is not painless or peaceful or dignified. In fact, in the vast majority of cases, it is a very painful death."[25]

The most recent report on assisted suicide in Oregon indicates that the complication rate for assisted suicide was around 10% in known cases, including seizures and difficulty ingesting/regurgitating. Furthermore, the data shows the range of time between ingestion of the lethal drugs and moment of death to be anything from 3 minutes to almost 6 days.[26]

It is very concerning that the Bill does not contain a list of the drugs to be used for assisted deaths.

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[24] The Economist, Letters to the Editor, 27th November 2021 Letters to the editor (economist.com)
[25] Last rights: assisted suicide is neither painless or dignified, Dr Joel Zivot, The Spectator, 18th September 2021 Last rights: assisted suicide is neither painless nor dignified | The Spectator)
[26] Oregon Death with Dignity Act 2023 – 2023 Data Summary) Oregon Death with Dignity Act: 2023 Data Summary

Question 5 - Health professionals

The Bill requires the direct involvement of medical practitioners and authorised health professionals in the assisted dying process. It includes a provision allowing individuals to opt out as a matter of conscience.

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

Medical professionals should not be involved in assisted dying, as their duty is to preserve life, not end it.

The Bill strikes an appropriate balance by requiring that there are medical practitioners involved, but also allowing those with a conscientious objection to opt out.

Assisting people to have a "good death" should be recognised as a legitimate role for medical professionals

Legalising assisted dying risks undermining the doctor-patient relationship

Other – please provide further detail

If you have further comments, please provide these

The care of human life to its natural conclusion, is entrusted to society and, in a very special way, to healthcare workers and is realised through programmes of care that can restore, even in illness and suffering, a deep awareness of their existence to every patient. The need for medical care is born in the vulnerability of the human condition in its finitude and limitations. Our vulnerability forms the basis for an ethics of care, especially in the medical field, which is expressed in concern, dedication, shared participation and responsibility towards the women and men entrusted to us for material and spiritual assistance in their hour of need.

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

Assisted suicide and euthanasia must be distinguished from a decision to forego medical procedures or treatment that are disproportionate to any expected results or because they impose an excessive burden on the patient and their family. In situations such as these, when death is clearly imminent and inevitable, one can in conscience refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted. To forego extraordinary or disproportionate means is not the equivalent of assisted suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death.[27]

The impossibility of a cure where death is imminent does not entail the cessation of medical and nursing activity. The judgement that an illness is incurable cannot mean that care has come to an end. The objective of assistance must take account the integrity of the person, and thus deploy

[27] Evangelium Vitae, Encyclical Letter on the Value and Inviolability of Human Life, John Paul II, 1995, para. 65 Evangelium Vitae (25 March 1995) | John Paul II (vatican.va)

adequate measures to provide the necessary physical, psychological, social, familial, and religious support to the sick.[28]

The 'option' of assisted suicide completely alters the doctor-patient dynamic and the wider provision of care in a deeply troubling way. In a society where assisted suicide is legal, care for life can no longer be considered an unqualified principle underpinning the provision of healthcare.

Deliberately bringing about a patient's death would be akin to crossing the Rubicon for a profession entrusted to act in the best interests of the patient and to first do no harm. People go to doctors and into hospitals for treatment. Legalising assisted suicide introduces death by prescription for people, many of whom will be vulnerable, in a chilling perversion of true healthcare.

Our Duty of Care (ODOC), a group of UK-based doctors opposed to assisted suicide, has declared that "any change in the law undermines the public's trust in healthcare professionals and would devalue the inherent dignity of frail, elderly, and disabled patients." ODOC also declares that "no doctor, nurse, or other healthcare professional should be forced to participate in euthanasia or assisted suicide, nor should they be obliged to make referral decisions to this end."[29]

It is significant that the Royal College of General Practitioners and the Association of Palliative Medicine in the UK are both opposed to assisted suicide and euthanasia.

[28] Samaritanus bonus, letter on the care of persons in the critical and terminal phase of life, Congregation for the Doctrine of the Faith Letter Samaritanus bonus on the care of persons in the critical and terminal phases of life (14 July 2020) (vatican.va)

[29] Our Duty of Care UK Declaration Have you signed the ODOC Declaration yet? (ourdutyofcare.org.uk)

Question 6 - Death certification

If a person underwent an assisted death, the Bill would require their underlying terminal illness to be recorded as the cause of death on their death certificate, rather than the substance that they took to end their life.

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

I support this approach because this will help to avoid potential stigma associated with assisted death

Other – please provide further detail

If you have further comments, please provide these

The approach to death certification proposed in the Bill is disingenuous. The whole purpose of the Bill is to permit a doctor to prescribe a lethal concoction of drugs to a patient with the intention that this will bring about their death. It is the lethal concoction of drugs that will end the life of the individual. To record anything else is false.

Question 7 – Reporting and review requirements

The Bill proposes that data on first and second declarations, and cancellations, will be recorded and form part of the person's medical record.

It also proposes that Public Health Scotland should collect data on; requests for assisted dying, how many people requesting assisted dying were eligible, how many were refused and why, how many did not proceed and why, and how many assisted deaths took place.

Public Health Scotland would have to report on this anonymised data annually and a report would be laid before the Scottish Parliament.

The Scottish Government must review the operation of the legislation within five years and lay a report before the Scottish Parliament within six months of the end of the review period.

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

The reporting and review requirements set out in the Bill are broadly appropriate

The reporting and review requirements seem excessive and would place an undue burden on frontline services

Other – please provide further detail

If you have further comments, please provide these

Question 8 – Any other comments on the Bill

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

Additional general comments in relation to the Bill:

Assisted suicide attacks human dignity and results in human life being increasingly valued on the basis of its efficiency and utility. Implicit in legal assisted suicide is that an individual can lose their value and worth. Moreover, assisted suicide represents a renunciation of the obligation of justice and charity towards one's neighbour and towards society as a whole.

What a sick person needs, besides medical care, is love; the human warmth with which sick persons can and ought to be surrounded by all those close to him or her, parents and children, doctors and nurses. A sick person, surrounded by a loving human presence, can overcome many ills and need not succumb to the anguish of loneliness and abandonment to suffering and death. Moreover, being dependent on others does not mean a loss of dignity. We are, in one way or another, dependent on others from the moment we are conceived, and this dependence can increase in our later years.

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

Further, proponents of assisted suicide peddle a false understanding of 'compassion'. In the face of seemingly 'unbearable' suffering, the termination of a patient's life is justified in the name of 'compassion'. This view of 'compassionate' holds that it is better to die than to suffer. In reality, human compassion consists not in causing death, but in embracing the sick, in supporting them in their difficulties, in offering them affection, attention, and the means to alleviate their suffering.[30]

Proponents of assisted suicide often argue for assisted suicide on the basis of autonomy. Autonomy, however, is not absolute. Almost every decision we make, even the most banal, routine, day-to-day decisions, are influenced by external factors. The decision to opt for assisted suicide cannot fail to attract external influences which will have a bearing on that decision.

In conclusion, assisted suicide: undermines suicide prevention; undermines the provision of palliative care; undermines trust in doctors; and it puts pressure on vulnerable people to end their lives prematurely.

The poor and vulnerable are already struggling to live. Parliamentarians in Scotland ought to offer them care and support to live, not a concoction of drugs to die. Killing is not the solution to ill-

[30] Samaritanus bonus, letter on the care of persons in the critical and terminal phase of life, Congregation for the Doctrine of the Faith Letter Samaritanus bonus on the care of persons in the critical and terminal phases of life (14 July 2020) (vatican.va)

health, poverty or any other social challenges. The state ought to support the provision of care, not deliberate killing, for those at the end of life.