Dying with dignity

An analysis of responses to a consultation by Jeremy Purvis MSP
“Few topics in medical law and ethics, or indeed in clinical practice, are so capable of generating as much heat (with or without the accompanying light) as end-of-life decision-making....the law’s approach to end-of-life decision-making remains surrounded by a cloak of obfuscation, and rests on premises which are less than consistent or transparently valid”

Professor Sheila McLean, Director of Institute of Law and Ethics, Glasgow University, Consultation Submission, 31st March 2005.
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Introduction

On 20th January 2005 the Death with Dignity Consultation was launched. The paper outlined the proposal to introduce a Member’s Bill which would allow competent adults, suffering from a terminal illness, and who make persistent and considered requests to die, the right to receive medical help to bring about their death.

The consultation paper put to the public the proposal that it would be a right of a capable terminally ill adult to receive a prescription for medication for them to self administer to bring about their death. Current law in Scotland is inconsistent with regards its policy of assisted dying. The proposed legislation aims to clarify that legal position. It further aims to provide a statutory safeguard to prevent abuse and ensure that the law is applied appropriately.

The main issues that the proposed Right to Die for the Terminally Ill Bill would address include:

- That the Bill would only apply to ‘capable’ patients who are adults and residents of Scotland and that the term ‘capable’ would be defined using the Adults with Incapacity (Scotland) Act 2000.

- That it would be the duty of the doctor (or multidisciplinary care team in a hospice or elsewhere) to explain any feasible alternatives when the patient requests assistance to die – alternatives being pain relief, hospice support and other palliative care packages as available.

- That this legislation would apply to patients diagnosed with a terminal illness that will result in death within 6 months

- That no medical professional or health care authority would be compelled to participate in the Act

- That a reporting mechanism and an annual report would be required to be published detailing incidents of prescriptions, as well as results of interviews taken with those requesting the prescription

- That the patient is central to all medical treatment decisions

The consultation closed on the 15th of April 2005 and the following is an analysis of the submissions received.
To assist in the analysis of this consultation, and in the interests of making a quantitative breakdown, submissions have been summarised into the following categories: support, opposition and neutrality. It should be understood that these have been categorised according to the comments made in each submission and by the judgment of the author. All quantitative results are therefore tantamount to that position.

No assumption is given as to the representative nature of each submission i.e. for representative organisations or professional bodies.
Summary

In total, 616 parties responded to the consultation ‘Dying with Dignity’ and the proposed Right to Die for the Terminally Ill Bill – an unprecedented number to a Member’s Bill. Submissions were made from NHS Boards, medical bodies, Local Authorities, Religious Groups and organisations, Elderly and Child Welfare organisations, euthanasia and pro-life interest groups and many hundreds of responses from medical professionals and private individuals.

An analysis of results shows that 346 respondents were in general support of Physician-Assisted Suicide (PAS) and a change in the law. 201 were opposed to the principle and to any change in the law. Whilst 69 submissions remained neutral, raising points or concerns or making suggestions, but not stating opposition or support for the purpose of a change in the law to allow terminally ill patients the right to die.

The general evaluation therefore shows the results of the consultation as being 56% in favour of the principles laid down in the paper, 33% opposed, and 11% neutral.

<table>
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<tr>
<th>Support</th>
<th>Oppose</th>
<th>Neutral/No registered position</th>
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<tr>
<td>346</td>
<td>201</td>
<td>67</td>
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<td>56%</td>
<td>33%</td>
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Dying with dignity consultation

Analysis

The consultation responses were divided into the following twelve sections for considered analysis:

1. NHS Boards
2. Local Authorities
3. Medical Bodies
4. Palliative Care Groups
5. Medical Staff (individual responses)
6. Religious Organisations
7. ‘Neutral’ Groups
8. Pro Physician Assisted Suicide Interest Groups
9. Pro Life Interest Groups
10. Academic Responses
11. International Responses
12. Individual Responses (miscellaneous)

The consultation paper set six specific questions for response by the public. They included:

Question 1: Please specify any concerns that you have with the proposal and how these could be addressed.

Question 2: What are your views on using the definitions of adult and incapable as set out in the Adults with Incapacity (Scotland) Act 2000?

Question 3: By whom should reporting mechanisms be administered?

Question 4: What time period, within which death is diagnosed, should a patient be entitled to request assistance to die?

Question 5: What would the financial burdens on the NHS, public sector and medical organisations or private organisations, arising from this Bill be?

Question 6: Do you have any further comments to make?

Not all submissions answered these specific questions, instead choosing to outline their views in essay or bullet point format. Therefore the following analysis of each section provides not only the responses made to the questions specified, but also includes the additional views and arguments expressed. For simplicities sake these additional arguments raised have been included under Question 6 and ‘Further Comments’.
NHS Boards

Seven NHS Scotland Boards responded to the consultation. They included:
- Ayrshire and Arran
- Fife (personal view from Dr Stella Clark, Acting Medical Director)
- Greater Glasgow
- Grampian (individual response from Dr Gordon Peterkin, Cross Systems Medical Director)
- Highland
- Lanarkshire
- Lothian

Of those that responded, Dr Peterkin of NHS Grampian fully supported the proposals, Dr Stella Clark of NHS Fife fully opposed the proposals and the remaining five Health Boards were neutral. In percentages this equates to 71.4% neutral, 14.3% in support and 14.3% in opposition.

Arguments raised in this section include:

Q1: Concerns

Three Boards made the point that a health authority opt out could result in a post code lottery for patients regarding provision of Physician Assisted Suicide (PAS).

Two suggested concern over the issue of lethal medication for home use in respect of the potential for risk or abuse in the community. It was also felt there would be a need for guidance for medical staff to ensure titration sufficient for that individual patient. One queried the circumstance of a patient being unable to physically administer their own lethal medicine.
Two Boards felt there could be a detrimental impact on the doctor–patient relationship. One stated it may affect relations between the patient and their family.

The relationship between PAS and palliative care was highlighted, the view of two Boards being that such care was necessary to ensure the patient was aware of the alternatives, another that PAS might impact on the development of palliative care.

One Board stated that eligibility for insurance cover was an issue and linked to this the wording on the death certification.

Q2: Definitions

Support for the definitions derived from the Incapacity (Scotland) Act 2000 was expressed as was the reservation at use of a definition based on the absence of incapability as opposed to the presence of capability. One view was that the definition from that Act was not an “all of nothing” concept and open to change from one instance to another and even in the same case over time.

One Board suggested that incapacity was a specialist area calling for psychiatric input.

Q3: Reporting

Views varied on this question. One Board felt that such a quasi-legal process would be out with their statutory remit and suggested a new system perhaps linked to the Office of the Public Guardian for Scotland. Another stated there could be a role for individual health boards but outlined an alternative model based on the Mental Health Welfare Commission for Scotland as put in place by the Mental Health Act. Another view was that reporting ought to be monitored by health authorities and the Procurator Fiscal.

Q4: Time Period

One view was that 6 months seemed appropriate, another stated the impossibility of accuracy in prognosis of death, and a third claimed a logical inconsistency in that if PAS was to be linked to poor quality of life then why limit provision to those with a terminal illness.

Q5: Financial Burden

One Board stated that this was difficult to estimate but unlikely to become a major financial concern whilst another believed the Bill would create a significant financial burden on all medical practitioners. One view, given
by a patient, was that it would be a cheaper alternative to caring for the terminally ill.

Q6: Further comments

Two boards welcomed the emphasis on the right of medical staff not to be involved in PAS if based on a conscientious objection to the practice. Two emphasised that there was mixed opinion of the proposal within their organisation and said their responses attempted to reflect the range of views held by their members.

One view was that a referendum should be held before any such legislation. Another Board expressed concern at what was perceived to be “an uneasy compromise between legally assisted suicide and medical euthanasia”.

One Board felt that the arguments proposed by the Member were strengthened by the systems already in place in other countries. It was further suggested that: “The development of this type of legislation related to “assisted dying” is also particularly important for the protection of medical practitioners in light of the Harold Shipman case by ensuring that end-of-life decisions made by medical practitioners are transparent and subject to scrutiny and safeguards”.
Local Authorities

Four Local Authorities responded to the consultation. They included:
- Aberdeenshire Council (individual response from Council officers)
- Falkirk Council (individual response from Council officers)
- North Lanarkshire Council
- Orkney Islands Council

Of those that responded, Falkirk Council was supportive of the proposals whilst Aberdeenshire, North Lanarkshire and Orkney Islands Council were neutral, equating to 75% neutral to 25% support.

Q1: Concerns

The main concern raised by the Local Authorities that responded to the consultation was that the protection of vulnerable adults needed to be the key priority in this proposal. A concern that was also raised by two of the four Councils was that the proposals ‘conscience clause’ could deny access to PAS in areas where Health Boards or GPs declined to participate. This was raised particularly by Orkney Islands Council who perceived a difficulty in initiating this legislation in small island communities.

One concern that was raised was that the proposals could be seen as discriminatory as it would not cover patients with chronic or incurable diseases such as Motor Neurone Disease or Multiple Sclerosis. A further specified concern was of the possible effect this proposal would have on both the medical profession and a patient’s family.

Q2: Definitions

Two of the respondents believed the Adults with Incapacity definitions were useful. Of these respondents one believed that there was need for further consideration of the implications of using these definitions whilst the other further believed that the term ‘incapacity’ is not necessarily an all-inclusive state and that this must be considered.
One Local Authority had concerns over the age considerations and the definition of adult starting at age 16. Another LA stated that there were other criteria to be considered under the law i.e. legal capacity and learning difficulties etc.

Q3: Reporting

One respondent believed that the reporting mechanism to administer this Bill should be similar to that in the Oregon model but specified that, in small communities, care would be required to ensure that individuals cannot be identified. Another respondent specified the need for reporting mechanisms to be extremely robust and to take account of more than just medical opinion.

Q4: Time Period

No specific comments were made on time period.

Q5: Financial Burden

With regards the financial implications arising from the legislation, the overall view was that there would be an increased burden on hospice and palliative services and further implications on the training of staff, the need for support stuff etc. It was also specified by one respondent that there is a need to consider the availability of resources for people who choose PAS i.e. hospice funding and local authority 24 hour support.

Q6: Further comments

One respondent argued that there was the need to recognise the role of the carer in this legislation and their legal position in the case of a patient being unable to self-administer the lethal dose. This was also seen to be the case for family members and the need to clarify their legal position if they assist the patient to take the medication.

It was also suggested that there would need to be a provision of a counselling service for patients to ensure that their decisions are not taken under pressure. Concerns were also raised about those with severe impairments being placed under pressure by the availability of this service.

One submission believed that there could become a risk that assisted suicide would become common practice. They further argued that there was no evidence to support the argument that GPs already help people to die. One respondent stated that they did not think it was acceptable for Scottish people to have to travel to another country in order to receive help to die.
Medical Bodies

Fourteen medical bodies responded to the consultation. They included many of the Royal Colleges, the General Medical Council, the British Medical Association, the Scottish Council on Human Bioethics and the Disability Rights Commission.

Of the fourteen submissions a total ten were opposed to the proposals outlined in the Bill whilst four were of a neutral position, which equates to 71% opposed with 29% neutral.

It should be noted that, following their submission on 6th of April 2005, the British Medical Association altered its position on Physician Assisted Suicide (PAS) from a stance of opposition to one of neutrality\(^1\). It should also be noted that the Disability Rights Commission has stated that it does not oppose the principle of PAS or its legislation and supports the principle of patient autonomy. In light of this 64.3% of medical bodies are opposed to the principle of PAS whilst 35.7% are of a neutral position.

\(^1\) The BMA Annual Conference took place on the 28th of June 2005. Conference passed the following policy statement with a vote of 53% in favour and 47% against:

"That this Meeting believes that the question of the criminal law in relation to assisted dying is primarily a matter for society and for Parliament. The BMA should not oppose legislation which alters the criminal law but should press for robust safeguards both for patients and for doctors who do not wish to be involved in such procedures."
Q1: Concerns

Concern was expressed by several bodies for the “profound implications” for the role of doctors, this role explained as being to cure the patient but where that was not possible then to ensure as high a quality of life as possible. The concepts of “healer” and “Killer” were juxtaposed. Six bodies were anxious about the consequences for the relationship between medical practitioner and patient, one citing the need to build trust again “post-Shipman”.

Two bodies were concerned about the mental state of a medical practitioner asked to perform PAS. It was felt there was a danger the consequences could become unbearable. Tied to this, four respondents emphasised the importance of conscientious objectors being able to opt out. One body stated that half of its members who had expressed a view would opt out if legislation was introduced. Two bodies expressed the view that the legislation could impact negatively on the career of those who objected as they may be “squeezed out” of clinical areas.

A number of bodies stated their concern that patients might come under pressure to opt for PAS against their (the patients’) wish. Linked to this was the view that vulnerable people must be free from any pressure or prejudice and the fear that “if PAS is seen as a good option for the strong and determined, it may also be seen as best for the depressed and unsure”. One body urged the need for proper exclusion of “psycho social factors” and clarity that a request for PAS was not being made for external pressures, real or perceived, explicit or implicit.

A disability group stated it was not opposed to PAS in principle but against the proposed legislation because it was believed this could threaten the lives of disabled people in the context of “ingrained institutional discrimination”. The danger of health professionals making certain assumptions about quality of life of people with either a disability or a terminal condition was highlighted.

One respondent found parallels with the Holocaust, suffering in hell, and the Abortion Act, claiming that doctors could become “the most dangerous individuals in the land”. Another respondent set out the slippery slope argument against PAS and alluded to the compulsory euthanasia enforced by the Nazis in Germany before and during World War Two.

A good number of bodies referred to palliative care and the need for more support for such provision, including the view that it can address the suffering of the terminally ill in all but the most extreme cases. One submission included a copy of an article titled “Care Of The Dying Patient” (Ellershaw & Ward) which concluded the hospice movement has: “challenged the prevailing death-denying attitude of our healthcare
system and champions a positive attitude to caring for vulnerable and dying patients” and that “a clear structure for care is needed to empower generic workers if we are to achieve the requirements of the NHS cancer plan that “the care of all dying patients must improve to the level of the best”.

One body claimed the “near unanimity” of European countries not finding PAS acceptable. Another expressed concern at what it perceived to be biased evidence from the Netherlands, Oregon and Belgium, suggesting a lack of evidence or data regarding “the problem” of those seeking PAS in Scotland. Linked to this, another body stressed the dangers of PAS outweighing potential benefits to a small number of “tragic cases”.

Q2: Definitions

Two bodies considered the definitions appropriate or acceptable. Three bodies queried whether under 16s would be eligible to apply for PAS, one of them describing this possibility as “foolhardy”. One body suggested that in the Netherlands PAS was initially only available to competent adults but debate there now extended to “handicapped newborns”.

One view was that the Bill could be interpreted as discriminatory against incapable adults. Another body felt that experience of working with the Adults with Incapacity Act was still limited and suggested that this Act was not intended to cover such purposes as PAS.

Q3: Reporting

Three bodies stated that PAS deaths should be reported to the Procurator Fiscal or somebody independent of the medical profession. This was felt important in order to ensure safeguards and transparency, with one body adding the need to monitor trends.

Q4: Time Period

Five bodies were of the view that in many circumstances it was difficult to be accurate with prognosis. One suggested that in many circumstances it was difficult to distinguish between 6 months and 1 year. One view was that the timescale needed to be very much shorter.

Q5: Financial Burden

Views varied between high and low financial costs. One of the former view suggested resources would be necessary for training, process, administration, regulation and audit.

Q6: Further Comments
It was suggested by one respondent that unbearable pain was uncommon though acknowledged that it was not always possible to alleviate distress.

One body opposed to PAS expressed sympathy for the motivation behind the Member’s proposal, discerning that motivation to be out of concern for patients’ suffering, respect for patient autonomy, and the need to protect doctors. Another of that view stated “However, I do agree with one doctor’s observation that a doctor who has never felt like providing euthanasia lacks compassion”.

Two bodies queried the impact on life insurance. One asked what would happen if a patient was incapable of putting a request for PAS into writing and would this discriminate against the illiterate, blind, and those with physical disabilities.

One respondent exercised an extended philosophical discourse on the meaning of “human dignity” and proposed that by opting for PAS the individual would be actually denying the very concept.

Two bodies were critical of what they perceived to be a blurring of the difference between the removal of life prolonging treatment and a deliberate intervention to end life, viewing these to be ethically distinct.
Palliative Care Groups

There were a total 23 submissions in this section and included responses from individuals and organisations involved in palliative care. There were also submissions from the Scottish Partnership for Palliative Care (SPPC) and the Association for Palliative Medicine of Great Britain and Ireland.

Of those that responded 17 were opposed to the proposals outlined in the Bill whilst 6 were neutral, equating to 74% opposed and 26% neutral.

The basic argument laid forth by the palliative care response is that this legislation is unnecessary as death with dignity is already achieved through symptom control and the holistic methods used in palliative and hospice care. The argument was also raised that the introduction of legislation to allow PAS will take away resources from palliative care services as PAS would provide an ‘easy way out’ and would be a cheaper service.

Q1: Concerns

A good many responses were concerned that this legislation will enhance the feeling many terminally ill patients have of being a burden and that this feeling would encourage many to take the ‘easy way out’. Linked to this was the concern raised by several respondents that depression is a major contributing factor to terminally ill patients’ requests to end their life. Some argued that depression could however be treated which raised the concern that this legislation was not necessary. A further concern was that the vulnerable would be placed at risk if this legislation was to pass.

A number of respondents were concerned about the effect this legislation would have on the doctor-patient relationship. The issue of damaging trust in the doctor was a common concern. Some submissions believed that the integrity of the medical profession was at threat by the concept of physician assisted suicide.
A common concern that was raised by a great many respondents in this section was the possibility that palliative care services would receive less funding and resources as a result of this legislation and resources being diverted to provide the PAS service. Some submissions also raised their concerns that, because palliative care services are not widely and universally available throughout Scotland, there would be discrimination against patients in certain areas who could not be offered all the alternatives to PAS. As such this proposal may not increase patient autonomy or promote equity of care. It was widely agreed that the best means of addressing this problem was to ensure that resources were made available to provide a universal palliative care service before the proposal to legalise PAS is to be considered.

A great many of the submissions in this section were concerned with the title of the consultation paper – ‘Death with Dignity’. They argued that dying with dignity already occurs in hospices and with good palliative and, as such, this Bill is unnecessary. Alternative titles included ‘Assisted Dying’ and ‘Medicine Assisted Death’.

One respondent raised their concern over the affect this legislation would have specifically on pharmacists and what their role would be. This was linked to another concern raised about which drugs would be used as a lethal prescription. Another respondent was concerned that the legislation was discriminatory towards ‘incapable’ patients as well as those who are capable but suffering from a chronic illness.

Q2: Definitions

One respondent questioned what is meant by ‘capable’ or ‘competent’. They further believed that the Adults with Incapacity (Scotland) Act 2000 is a grey area in palliative care as is the term ‘terminal’ which, in palliative care circles, means the last 1–72 hours of life.

Several respondents questioned what would happen if a patient could not write their own written request. One respondent went so far as to say that a patient is only truly competent if symptom free at the time of a PAS request.

One respondent believed it is sensible to use the Adults with Incapacity Act definitions but further questioned the role of Power of Attorney and the ‘capability’ of the Attorney. The respondent also raised their concerns over the influence that clinical depression would have on a patient’s capability.

One respondent believed that the AWI Act is poorly understood and under-utilised whilst two other respondents believed that capability and competence are difficult to accurately assess and agree that depression may too play a factor. One respondent believed that the proposals
introduce inequity of care by including capable patients but not including incapable adults.

One hospice submission argued that effective and reliable monitoring of the AWI Act is needed – particularly to reduce confusion.

Q3: Reporting

One respondent argued that the Scottish Executive should have responsibility for administering the reporting mechanism. Another believed that reporting should be to the CMO Scotland or the Public Guardian however further questioned the affectivity of safeguards in preventing underground euthanasia. A further respondent argued that the reporting mechanism should go to the Courts or the Procurator Fiscal.

Q4: Time Period

A great number of responses to this question argued that diagnosis was notoriously uncertain and difficult to accurately predict, particularly within a time frame of 6 months. One respondent argued that the proposed Bill would not help the severely disabled or in pain and who have a relatively normal life expectancy. This was supported in another submission which argued that quality of life should be a key factor for consideration of PAS requests rather than setting a time period. This submission further argued that by setting a time period for diagnosis the Bill is giving too much power to the clinician who must make that judgement. Autonomy is not therefore passed to the patient but to the doctor.

One respondent agreed with the principles of the Adults with Incapacity Act but had concerns over the practical concerns of enacting them, particularly in hospices. The respondent had further reservations that non-psychiatrically trained medical staff would be assessing a patient’s ‘capability’.

One Palliative Medicine Consultant raised their concern at the varying patterns of disease in each patient which would greatly affect their diagnosis of time left to live. The patient’s sex, previous medical history, weight and age are all factors that make a prognosis of death so difficult to assess in each individual case. The possibility of wrong diagnosis was a further concern which would make the 6 month period arbitrary.

One hospice submission believed that requests for PAS should come following a counselling period and monitoring of deterioration of symptoms (resulting in the decision making by individual to request PAS).
Q5: Financial Burden

One respondent perceived costs in setting up the reporting mechanism (that are safe, ethical, acceptable and properly governed) and payment of the GPs who participate. The respondent also raised the financial difficulties associated with PAS patients who ‘go private’.

One respondent saw the proposals as a way of saving resources and reducing investment in end of life care but also believed that there may be costs involved relating to the ‘opt-out’ or conscience clause. A number of submissions raised concerns over a short-fall in palliative care resources due to the provision of PAS.

Q6: Further comments

The Scottish Partnership for Palliative Care (SPPC), the umbrella body for palliative care bodies and staff in Scotland, acknowledged that for a small number of individuals the existential and physical suffering of the dying process will not be relieved by palliative care, and that the issue of caring satisfactorily for these patients must be addressed. However they believe that the proposed Bill is disproportionate in its implications and effects to the nature and scale of the problem. They further believe that the detailed content of the proposal Bill is seriously flawed and would do greater harm than good.

The Association for Palliative Medicine of Great Britain and Ireland believes that a great many of its members would not support the proposals and provided in house survey results taken in the summer of 2003. They did however welcome the conscience clause in the Bill and further stated that this debate requires more insight into patients’ views and attitudes towards PAS.

Two respondents believed that the proposals would lead to a two-tiered system within the medical profession. One respondent believed that the two tiers would be between the palliative care sector and the PAS sector, whilst the second respondent related the two tiers to the conscience clause and the difference between those doctors who participated in PAS and those that conscientiously objected.

Two respondents believed there would be serious implications arising from the Bill’s proposal to allow health authorities to opt-out of the legislation. In particular it was perceived that this would be detrimental to the care of the patient and could lead to discrimination due to location or postcode. One respondent believed that, if passed, health authorities should be made to comply with the Act.

Several submissions were concerned that the proposals in the Bill would take interest away from palliative care. In particular the concern was
raised that research and funding would be disrupted as PAS was the easier and cheaper option. Several submissions argued that attention should be given to providing a better service for palliative and hospice care.

A number of respondents welcomed the debate that this consultation paper and had opened up, particularly as a means of leading to greater ease and openness in addressing end of life issues.
Medical Staff (Individual)

Seventy Seven responses came under this section. They include responses from all individual medical professionals and medical students (minus palliative care staff). Overall 42 were opposed to the Bill, 16 were in support and 19 were neutral. In percentages this equates to 54.5% in opposition, 20.8% in support and 24.7% neutral.

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Q1: Concerns

The key concern raised by this section was that of the affect this proposal would have on the medical profession as a whole. A great many submissions were concerned specifically with the affect it would have on the doctor-patient relationship and the balance of trust. Some argued that the profession was already suffering from a post–Shipman fall–out and the balance of trust was one that needed to be built. The proposals were seen as contrary to this. Moreover the actual role of the doctor in the Bill’s proposals was also a significant concern to many of the respondents. In particular many were concerned that, by participating in PAS, they would be breaking their Hippocratic Oath and the concept of ‘First Do No Harm’. Moreover many argued that the patients might have a right to die but they do not have the right to expect medical professionals to prescribe the medication to help them die. Another common argument raised in this section was that life was fundamental and that legislation of this sort was detrimental to that philosophy.

A further cause for concern to many of the submissions in this section was that legalisation for Physician Assisted Suicide would result in a slippery slope which would eventually lead to a relaxing of the laws and paving the way for legalised euthanasia. Many respondents argued that the Bill’s proposals had connotations with the Abortion Act which, they believed, had been relaxed and was now more widely available than it first intended. One respondent believed that that ‘opt-out’ clause would be subject to corrosion similar to that seen following the Abortion Act.
A number of submissions were concerned that the Bill’s proposals would have a profound affect on the vulnerable and on those who feel like a burden, who would begin to feel that they were compelled to request the right to die. This in linked to a response by one doctor who argued that the option of PAS will bring an extra dimension to a patient’s distress.

Several respondents were concerned that the proposals did not include illnesses such as Motor Neurone Disease, Multiple Sclerosis, and COPD and that this was discriminatory to those with chronic illness. The concept of discrimination was also raised by another respondent who believed the Bill might discriminate against ‘incapable’ adults due to its use of the Adults with Incapacity Act definitions.

A number of respondents believed that there should be a limit set on personal autonomy and that this proposal goes one too far in the way of patient autonomy. Another submission was concerned that even if a patient did have the right to die, they could not necessarily request it due to the conscience clause and the lack of a doctor willing to provide them with the medication.

Several submissions of support instigated the argument that animals are able to be put down to stop their suffering but humans are denied the right and that, as a result, this legislation is to be welcomed.

Q2: Definitions

Five responses agreed that the definitions are reasonable.

One respondent believes that current tests of capacity are too weak to use in this proposal as they have been designed around ‘consent’ and not ‘course of action’: this was supported by another respondent who stated that the assessment of capability is very imprecise, even with the AWI Act, and further believes that capability depends on many factors including health and mental functioning (both of which can vary on a daily basis).

Three respondents question the definition of ‘adult’, one arguing that the age of adulthood should be raised to 18 in this respect. One respondent believed that there would be a need to discuss ‘capacity’ with the consultant psychiatrist colleagues. Two respondents argued that there are ‘grey areas’ in the definitions of ‘capable’ and also in end of life care overall. Theses issues would need to be addressed in the writing of the Bill.

Q3: Reporting

Three respondents believed reporting should go to the Local Health Authority and the NHS. One stated that annual reports should be issued
by the Scottish Executive Health Department. One respondent believed reporting should be administered by the organisation involved and the Scottish Executive.

One submission argued that, prior to Shipman; the reporting mechanism should have been the General Medical Council. However, post–Shipman, reporting should be administered by an independent medical/legal/lay professional group.

One respondent was impressed by the Netherlands example of reporting and approves of open reviews that are published regularly. Another respondent believed that, if the reporting mechanism is to be related to the Oregon example, this must also be in line with guidance and legislation resulting from the Shipman enquiry. The respondent further believed that administration systems should be used for the recording of controlled drug usage and monitoring.

Another submission stated that the reporting mechanism must involve GPs who have known the patient in former health before the terminal illness. The submission further stated that this would require time and administrative support and that this will have financial implications. Reporting administration by participating medical practitioners was supported by another respondent.

**Q4: Time Period**

One respondent believed that the time period should depend on the illness – it could be months, it could be days – they argued that preferably the request could be made when that someone’s life becomes ‘no life’

One GP argued that the 6 month timescale is too long and that a few days or a week or two is more realistic. They further argued that it would require two doctors confidently predicting death within that time and one of the doctors involved must have a long-standing relationship with that patient (knowledge of pre-morbid state is essential in order to be confident of autonomy)

One respondent believed the 6 month timescale was adequate eligibility but did not suggest a time period for being allowed to make that request following diagnosis.

One carer who responded specified that request for PAS should come after a minimum 60 days of diagnosis having elapsed; that they receive a second concurring medical diagnosis within that period; that they have received counselling on all feasible alternatives and; that the carer concurs with the decision.
A great many of respondents expressed their view that diagnosis was difficult and making a 6 month prognosis of death was often impossible. Some responses used examples of their patients who had been diagnosed with 6 months or less to live and who then lived for another couple of years. On the reverse one respondent argued that a cancer patient was diagnosed with 6 months left to live but died very shortly afterward due to the nature of their illness. The overall concern was that setting any time period was impractical due to the uncertainty of diagnosis.

One doctor was concerned over providing legal provision to those terminally ill patients if they are expected to live less than 6 months – he states that on estimate of all patients who are told they have less than 6 months to live, 25–30% would live longer than this. Another respondent believed that every case should be considered on its own merit but that a minimum 3 month timescale from diagnosis should be put in place.

One submission argued that a gauge of timescale should be in correlation with clinical reasoning and vigorous recording of discussions with the patients and their separate requests to die. Another response stated that a request for PAS should be made any period after a prognosis had been made. The respondent further believed that a mechanism should be put in place for those patient’s who go on to revoke their request.

Q5: Financial Burden

Several respondents believed that there would in fact be financial savings from this proposal due to the reduction in unwanted expensive treatments to prolong life. One respondent said that there is potential to save money from ‘bed-blockers’.

One submission argued that the proposals would not be cost neutral due to the time needed to counsel patients. The respondent believes that this would in fact need to become a specialism in its own right. They further believe that there will be financial implications on life insurance which will need to be clarified by legal safeguards. The financial cost of counselling for patients was also raised by another respondent.

One respondent perceived there to be financial implications involved in the establishment of a NHS system of administration, governance and audit. Further costs were considered on education programmes, occupational health counselling and by an increased risk of litigation against medical professionals etc. The costs of setting up a reporting system, the added bureaucracy this would create and the additional time this would have on professionals were issues also raised by several other respondents.
Two responses argued that the emotional burden had not been considered in the consultation whilst another respondent argued that the right to die should be not be considered in terms of a commodity.

**Q6: Further Comments**

One submission stated that that this proposal might attract the wrong kind of person to work within the NHS, quoting this to be the ‘Shipman Shadow’. They further believed that Oregon is poor example as they also have the death penalty by lethal injection and this does not correlate with Scotland.

Several responses believed that more funding and resources should be given to palliative care rather than encourage an additional option which could be perceived as the ‘easy way out’ as well as the cheaper alternative.

A number of respondents believed the proposals should be extended to include those suffering from severe disabling illnesses as well as chronic and painful illness.

One respondent wished the Bill a speedy passage through Parliament and further argued that if animals could be put down at the end of their life then humans should also have that right to choose.
Religious Organisations

Twenty eight submissions were placed in this category. Responses came from many of the major faith denominations in Scotland including Christian, Catholic, Jewish, Mormon and Baha’i. It also included responses from the Christian Medical Fellowship, the Nurses Christian Fellowship of Glasgow, one member of the Guild of Catholic Doctors, and a personal response from the Chairman of the Lawyers Christian Fellowship. As well as responses from religious organisations this section also includes submissions made by individual church groups and individuals who express a religious belief.

Of those that responded 23 were opposed to the proposals, 3 were in support and 2 were neutral, equating to 82% opposed, 11% supporting and 7% as neutral.

The main argument that respondents in this section made is that life is God given and has intrinsic worth. It is therefore morally wrong to hasten death through artificial means, to do so would be playing God.

Q1: Concerns

A number of respondents were concerned by the social consequences that this legislation would produce. In particular respondents were concerned about the emotional pressures on a patient’s family and friends, the role of the medical professional in society, and the stigma that is attached to assisted death.

Several submissions outlined the moral distinction between allowing someone to die and causing that person to die. In many cases respondents believed it was morally acceptable to allow someone to die by withdrawing treatment if it had become futile but they did not believe it to be morally acceptable to assist someone to die through a lethal prescription.
A great many responses in this section were concerned that terminally ill patients would become to feel like a burden and choose to request PAS as a means of relieving that burden on their families and carers. A number or submissions also outlined their concerns this Bill would have on the vulnerable in our society.

One response believed that this proposal was crossing a very important line in society. They further argued that it would inevitably lead to involuntary euthanasia.

One respondent was concerned that the proposals would increase the power of the medical profession and not the autonomy of the patient. They further argued that if compassion is the driving force behind the member’s proposals then this can already be found in the provision of palliative care.

The overall concern expressed in this section was that the right to life is God–given and only God can take that away; the sanctity of life is paramount. This was supported by all Christian denominations as well as the Jewish Council and the Catholic Parliamentary Office.

Q2: Definitions

Three respondents agreed with the definitions. One religious body raised their concerns over the definition of a ‘capable’ adult whilst another had concerns over the safeguards relating to the fine–line between a ‘capable’ and what is deemed ‘incapable’ request.

One respondent argued that the greater the degree of medical intervention the greater the degree of capability required before consent is in fact valid. They believe that assessing capability is not an exact science and doctors must take into account the influence of depression. The respondent also questioned whether decisions are ever truly voluntary.

Q3: Reporting

One respondent stated that a reporting mechanism to regulate covert PAS is an argument by *reductio ad absurdum* – we would not legalise murder to regulate covert killing. This is supported by their argument that there is no evidence that legalisation would remove underground euthanasia.

One respondent believes that a central recording office would be essential in administering a reporting mechanism.

One Church group argues that the need for a reporting mechanism was used in the Abortion Act and has lead to a liberalisation attitude towards abortion.
Another respondent believes that the high levels of paperwork involved in reporting in the Dutch example, and the following of strict regulations have lead to resentment. They suggest that a solution would be to introduce a better system gaining information about requests for PAS without legalising it.

Q4: Time Period

Again the main response to this question was that diagnosis cannot be certain. One respondent supported this view however set a time period, between the time of diagnosis and the ability to request assistance to die, as between 6 weeks and 2 months.

One respondent argued that death can only be diagnosed when dying; dying is recognised in palliative care circles as a 48 hour period; terminal illness is diagnoses as having less than 6 months to live - this is an arbitrary judgement for the DWP criteria (DS1500).

Another respondent raised the argument that prognosis may change with the progress of science.

One Church body argued that setting a criteria or time period would leave the door open to abuse.

Q5: Financial Burden

Three respondents believed that financial concerns should not enter into any debate on end of life issues. One argued that the ending of ones life should not be considered as one of a range of healthcare provisions, and that doing so may encourage some to feel obliged to end their lives if they feel like a burden.

One respondent believed that this legalisation would produce a reduction in costs but further argued that financial implications should not enter into the debate. Another respondent believed there may be issues arising in relation to staffing, especially with regards the conscience clause which will limit medical staff in virtually all fields of the profession.

One submission argued that PAS would threaten the existence of charitable hospices – if a hospice is associated with PAS they may not receive the charitable gifts and fundraising that produces up to 60% of their income. Another respondent stated that not all treatments are available to all and the cost of medicine is often a factor. They believe that the cost of keeping someone alive may influence decision making and argue that this proposal could turn into a pro-active money saving approach for the NHS.
Q6: Further Comments

Several of the Christian denominations argued that it was the Church’s duty to act with compassion however they could not in conscience support the proposals and instead argue that more resources should be provided to palliative care.

One submission of support gave the argument that the concept of God waiting to take one’s life when he is ready is outdated. We have the right, if the patient so wishes, to act with the mercy of God to bring hopeless suffering to a peaceful end.

The Baha’i Council of Scotland gave a neutral submission stating that their teachings indicate that God gives us life and that death is simply moving onto another stage of existence. There is nothing in the Sacred Scriptures regarding PAS and it is their belief that it should be left to the individual conscience to decide. They further believe that any legislation should be of a general nature in order to give the Courts plenty of scope to make appropriate judgements on individual cases.

One Church body questioned whether doctors would want this additional responsibility especially as there is too much potential for abuse, again quoting the example of Harold Shipman. They further argue that it would place too much pressure on GPs.

One respondent believed there was a need for further research on the effects of PAS, especially on a patient’s loved ones.
‘Neutral’ Groups

Eleven responses were placed in this section. They included submissions from various interest groups such as the Scottish Motor Neurone Disease Association, the North of Scotland Cancer Network (NOSCAN), the British Geriatrics Society (Scotland), Marie Curie Cancer Care, the Parkinson’s Disease Society and Care for Scotland. Submissions were also made from the Association of Directors of Education Services (ADES), the Public Services Ombudsman and the Law Society of Scotland stating their neutrality to the legislation.

Overall eight of the submissions were neutral. These included the Scottish Motor Neurone Disease Association, NOSCAN and the Parkinson’s Disease Society of the UK. The three submissions of opposition were made by the British Geriatrics Society (Scotland), Care for Scotland and Marie Curie Cancer Care, equating to 27% opposed to the proposals, with 73% of a neutral position.

Q1: Concerns

Concern was expressed by one group that there should be no loopholes or ways in which procedure could be abused, and another that safeguards should include consultation with the patient’s clinical team and also their family or carers. There was a recommendation that the Bill be tightly drafted particularly regarding the definition of terminal illness.

It was suggested that doctors should have a duty to set out alternatives when PAS was requested by a patient.

Three groups were concerned with how vulnerable groups such as older people or those with a disability might be pressurised to request PAS. One group drew attention to the fact that people with a motor neurone condition would not be able to avail themselves of PAS i.e. they might not be able to self-administer.

There was one view that focus would shift from providing the best palliative care to “death on demand”, and another that any debate about PAS was “inappropriate” until everybody was able to receive good quality palliative care. The latter group did however acknowledge that the existential and physical suffering of a small number of patients could not be relieved by palliative care.

One group stated that it could not see how local authorities could opt out and, if they could, then how this would be of benefit to anyone.
The “slippery slope” argument was proposed by one group with reference to the experience of PAS in the Netherlands.

Q2: Definitions

One group agreed this as acceptable, another expressed concern for adults who were less mentally capable but suffering the same horrendous illness as anyone else.

Q3: Reporting

One group stated the medical profession should do this. Another was of the view that it should be carried out by a medical care team within the Procurator Fiscal’s office and in addition the prescribing doctor should report the writing of a lethal prescription to the local health authority.

Q4: Time Period

One group stated the need for two verbal requests separated by one month in order to allow for any change of mind from the patient. Another group suggested that if total period from diagnosis to request for PAS was six months then this would coincide with the DS 1500 arrangements. Two groups opined that prognosis is neither easy nor realistic.

One view was that there should be a cooling off period of 14 days plus an obligatory assessment by a specialist palliative care team.

Q5: Financial Burden

One view was that what was proposed constituted “a price worth paying”. Another envisaged no financial burden on the system except possibly in terms of greater support for carers in order for loved ones to be able to die at home. One group envisaged some concern that the financial burden might allude to costs saved from avoided healthcare, in addition to a new administrative burden.

Q6: Further Comments

Two groups declared their concern for the impact on insurance policies, one finding the stated inability of the proposal to make provision for this area to be “problematic”.

One group viewed the proposal as an “excellent way forward” in providing more control to patients at the end of their life but emphasised the need to build in safeguards so that the choice of PAS does not become the norm.

Another view was that PAS was “internationally condemned” and the belief that right to die would become a “duty to die”.

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Three groups touched on palliative care, one stating that focus should be on improving all aspects of such care rather than defining condition under which “doctors become killers”. Another urged that government ought to ensure the very best care for everyone who needs it (as it believed only then would there be a genuine choice for patients who may wish to end their lives). The third alluded to palliative care in stating that in 95% of cases the unbearable can be made bearable and even in the remaining 5% the patient can be helped so that nobody need die in agony.
Pro-Physician Assisted Suicide (PAS) Interest Groups

This section contained 28 submissions made by individuals and organisations that fully support the principle of Physician Assisted Suicide and the right of the patient to die. Responses include those from the following action groups:

- Voluntary Euthanasia Society;
- Friends at the End (FATE);
- British Humanist Association (including the Humanist Society of Scotland);
- UKActNow.org;
- Lib Dems 4 Patient Choice;
- and individual members of these organisations.

All submissions in this section are in support of the proposals to allow terminally ill patients, diagnosed with 6 months or less to live, the right to choose PAS - 100% support.

Q1: Concerns

The concerns raised in this section were minimal. One was raised by the British Humanist Association that adequate safeguards were included. Friends at the End also called for a ‘pre-need’ statement or living will to be honoured in the case of an individual being "incapax" and thus still allowing their wishes to be carried out. The Voluntary Euthanasia Society suggest that the proposed Bill be modelled on the Assisted Dying for the Terminally Ill Bill and the Committee Report’s suggestions be used. In its submission the VES raised all possible concerns that were associated with assisted dying legalisation. In each instance they provided evidence and arguments against such concerns.

The British Humanist Association (supported by the Humanist Society of Scotland) also raised its concern that this legalisation would be prevented because of religious feeling against it. The Association feels that religious opinion should not dictate legalisation or be forced on those who hold no religious views.

Q2: Definitions

The definitions using in the proposals were acceptable and only four of the submissions made clear to answer in this instance.

Q3: Reporting
The administration of a reporting mechanism raised several options. One respondent believed it should be a joint consultation between legal and medical authorities. Another believed an officer similar to a coroner and titled ‘Assisted Dying Commissioner’ should be created. One respondent believed a Public Guardian, who would already have legal responsibility for registration of powers of attorney, should be the reporting mechanism. Another respondent argued that reporting should be undertaken by an administration of doctors involved and an independent body of BMA representatives, patient and nursing associations and assisted by legal staff.

Q4: Time Period

The period within which death is diagnosed and entitlement to request PAS also raised several alternatives. One respondent preferred requests or declarations to be made in advance of illness (i.e. advance directive) and that legalisation uphold this statement. Another submission suggested that, following a two week period from death being diagnosed, the patient should have the right to request PAS. Another respondent suggested a minimum of 48 hours from diagnosis of terminal illness to request PAS and up to one year from diagnosis to implementation.

Q5: Financial Burden

The majority of submissions perceived that there would be no obvious change, but that there was the possibility that money would be saved in unwanted costly end of life treatment. Other submissions perceived that there could be financial costs in paying for reporting mechanisms and in public legal services.

Q6: Further Comments

The majority of responses in this section were registers of support or a call for speedy and successful passage for the Bill. The following supportive arguments were summarised by the Voluntary Euthanasia Society in their response;

- Good quality palliative care cannot meet the needs of all dying patients;
- A significant number of terminally ill patients want greater choice at the end of their lives including receiving assistance to die at a time of their choosing (73% in a study by Wilson, 2000; 80% in a study by Sullivan 1997). The fact that assisted dying remains prohibited serves to drive the practice underground, without safeguards and transparency. In such circumstances, the potential for abuse and botched suicides increases;
- Regardless of what the law says, some health professionals in exceptional circumstances appear to break it out of compassion and respect for the wishes of their terminally ill patients;
- Currently, terminally ill people whose suffering is unbearable may with or without the help of a loved one, attempt to end their own lives sometimes with deeply distressing consequences, not just for the patient but also the relative. In an NOP survey conducted in September 2004, 50% of the public were willing to break the law in such circumstances;
- An increasing number of dying patients are seeking help to die abroad from a Swiss based organisation called DIGNITAS. This organisation works without stringent safeguards and guidelines;
- Evidence from Oregon and the Netherlands shows that fears of the slippery slope have not materialised. Further, such evidence shows that it is far better to provide for medically assisted suicide within a properly regulated, open and transparent system;
- The Bill draws on the experience of Oregon in particular but it has been adapted for the UK health service. The Bill would not only deliver patient choice but also help to take the fear out of dying and the dying process;
- There are many more safeguards in the Bill than in any other end of life medical practice. When coupled with guidelines by the BMA and GMC, the Bill would be effective in protecting the vulnerable groups within our community;
- There was unanimous agreement amongst the House of Lords Select Committee that the acceptability of assisted suicide or voluntary euthanasia is an issue for society to decide;
- It is clear that the vast majority of society (including elderly and disabled populations) support a change in the law. This public attitude, alongside a growing recognition of the importance of patient autonomy in medical decision-making and recent legal judgements, make it likely that this social trend will have increasingly important influence on this debate and;
- Over the last ten years medical opinion with regards assisted dying has moved. Many healthcare professionals now support a change in the law. This is highlighted by the Royal College of Physicians and the Academy of Medical Colleges taking a neutral (versus opposed) stance towards the Bill.
Pro-Life Interest Groups

This section contained a total of 31 submissions from individuals and organisations that fully opposed the proposed legislation. Responses include those from the following action groups:

- ALERT (Against Legalised Euthanasia – Research and Training);
- First Do No Harm;
- The ProLife Alliance and;
- The Society for the Protection of Unborn Children (SPUC)

Many of the submissions were made from individuals reiterating the SPUC submission, believed to have come from the SPUC membership newsletter.

All submissions in this section are opposed to the proposals – 100% opposed.

It should be noted that none of the Pro-Life Interest Groups or individual submissions made specific answers to the questions raised in the consultation. The following is therefore an outline of the arguments raised against the Bill’s proposals:

The main argument raised in this section was that the right to life is inalienable and that there is no right do die (as specified by Article 2 of the European Convention on Human Rights). One respondent was concerned that the proposals are discriminatory as they only allow the terminally ill the right to die. Individuals would be categorised and would result in them no longer being protected by the laws that protect the whole of society.

A number of respondents feared that the proposals would result in a slippery slope as there would be constant pressure to widen the scope of the law.

One respondent argued that if a patient gives up their right to life they would also be giving up their right to autonomy. This was supported by another respondent who believed that patient autonomy would be reduced as a result of this Bill as it places too much power in the decision making abilities of the medical profession.

A major concern raised was that the proposals would put pressure on those patients that feel like a burden. Another major concern was the affect this legislation would have on the role of the doctor and the doctor–patient relationship. One action group argued that this legislation would turn doctors in to killers. Furthermore it was argued that the
legislation would split the medical profession between those who are willing to perform PAS and those that conscientiously objected.

Two of the submissions argued that drugs do not have a uniform effect; the drugs affects would depend on the medical condition of the patient, their age, weight and nutritional status would all play a part and some narcotic drugs have an ‘idiosyncratic response’. In such a case a doctor would be relied upon to directly assist the death.

Several submissions argued that this legislation would result in a decline in standards of palliative care as PAS is a cheaper and easier option.

It was argued by one action group that it is the duty of the State to protect its citizens from harm. They argue that this proposal is contrary to that duty.

A comparison of the results from sections 7, 8 and 9 shows that there was a 49% opposition to the proposals, whilst 40% were in support and 11% neutral.
Academic

Eleven submissions were categorised as Academic responses. They include responses from various university lecturers and professors and also from leading law and ethics intellects. There were a total of five submissions made in support of the Bill’s proposals whilst two submissions were in opposition to the Bill. The remaining four responses were neutral.

Q1: Concerns

Professor Sheila McLean stated she had no concerns about the proposed changes to the law given her view of that the current legal position was “untenable” and “profoundly inconsistent”.

She referred to a theoretical adherence to the sanctity of life in the law but derogation in some circumstances, such as case involving severely ill or disabled infants or patients in PVS or near PVS. She argued that such an approach did “not provide a transparent and consistent ethical basis for permitting death in some circumstances and not in others”.

One respondent stated that PAS should be available to people in the end stage of an incurable disease and not to disabled people in general, another expressed no concern for the principle of what was being proposed but considered a broader discussion of the detail necessary and particular need for safeguards for the vulnerable.

One view was that a law should not be introduced that was “in contrary to the law of God”.

One respondent suggested that in the consultation paper “support processes” were not made explicit and queried whether medical
practitioners would be able to opt out of support/guidance prior to PAS itself.

Another respondent expressed the view that legislation would not alter the fact that much of the job of deciding whether an individual was reasonable in wishing to end his life would still be undertaken by the courts.

Q2: Definitions

Three respondents believed it made sense to draw on the definitions already on the statute books. One suggested that this seemed feasible but there should be an additional clause to cover those scenarios where a patient was unable to provide their request verbally or in writing, the not being able to sign your request concern being echoed by another respondent.

Q3: Reporting

Views varied between: the need for a central reporting agency with stringent quality assurance mechanisms, administration through the Crown Office; the need to gather empirical evidence so the law could be revised if there was abuse; by the courts; and by the courts and reporting to the Procurator Fiscal.

Q4: Time Period

Three respondents pointed out that prognosis was not an exact science though one of those accepting the “political” need for such criteria. One asked what would happen if the patient became “incompetent” during the process. One respondent agreed there should be limits but did not consider that remaining life-time should not be decisive criteria, suggesting the key elements ought to be: terminal illness, frequent and “sincere” requests for PAS, and unbearable pain.

Q5: Financial Burdens

No respondents considered the proposal itself would add a financial burden albeit one suggested that palliative care should be free at point of access and through the NHS.

Two respondents believed that PAS might actually ease the financial burden on individuals and organisations in terms of there being fewer patients in expensive long-term care, but adding this should not be a deciding factor. One stated the view that it would not be appropriate to have private organisations involved in the process.

Q6: Further Comments
Two respondents emphasised the need for no pressure or compulsion on individuals or authorities to participate in the Act and one called for a conscience clause similar to that in the Abortion Act of 1967.

One perspective of the overall debate was that sides could be drawn between those in favour of extending the rights of the individual versus those preoccupied with the concept of "consequentialism". The same respondent made a plea that the debate be argument based as opposed to an exchange of statements of belief, however sincerely held those beliefs.

There were a number of critiques of the "slippery slope" argument including a suggestion that the view that PAS would lead to legalised murder was analogous with the claim that permitting sexual relations would mean permitting rape.

One respondent set out a counter to the "slippery slope" view on the following basis: 1) safeguards built into PAS to preclude non-voluntary or involuntary euthanasia (notably the premise of patient autonomy whereby the starting point of the process is their request as opposed to a doctor’s judgement of value of life, plus the requirement for doctor’s assent including a diagnosis of terminal condition as opposed to decision-making based on non-medical grounds); and 2) empirical data in those countries that have legal PAS refutes the claim that this leads to an increased acceptance or occurrence of non-voluntary or involuntary euthanasia.

The meaning of pain and what constituted "intolerable" was outlined by one respondent who suggested it was complex and varied and it would be presumptive to decide how another human being ought to deal with it. It was pointed out that palliative care itself may be felt intolerable by some who may become dependent on its provision. It was further suggested that the consideration of others in the process (notably doctors) was not an objection to PAS given their assistance would be equally voluntary.

One respondent said there was some research to indicate that palliative care could encourage patients to take control over their end of life, something it was suggested that the palliative care movement had yet to recognise.

One respondent stated the view that the term "right to die" was meaningless, given the inevitability of death, and the issue is really that of the "right to chose to die". The same respondent stated that the patient's interests covered the right to self-determination i.e. the right to live life as one wishes even if this may damage health or lead to a premature death. That the right of the individual in this context is paramount, it was suggested, is already well established in law.
Another made reference to philosophers of such note as Kant and Locke and explored the role of “personhood” in the end-of-life debate, concluding that the right to die was a “critical paradox”.

One respondent emphasised that safeguards should include that no one involved in PAS should be in a position to benefit under the patient’s will.

One respondent raised the issue of insurance policies and the need to clarify this in the context of PAS even if it was not a matter within the competence of the Scottish Parliament.

One respondent called for the Member to “embrace the culture of life and not the culture of death”.
International

There were a total of 20 responses made to the consultation from outside the United Kingdom. They include respondents mainly from countries that have legislated on Physician Assisted Suicide and/or euthanasia such as Oregon, Belgium, Switzerland and the Netherlands. Responses were also received from as far away as Australia and Bermuda.

The majority of submissions were from professionals who had first hand experience of the operation of Physician-Assisted Suicide and/or euthanasia legislation.

The overall section response to the proposal laid down in the consultation was very positive with 15 of the 20 respondents in support. The remaining 5 submissions were of a neutral position and mainly from academics. One neutral submission was from the Ombudsman and Director of the Oregon Health Services University Department of Patient Relations. This response included the issues believed to be important in legislation on this issue.

75% of the international response was in support for this Bill. The remaining 25% were of a neutral position.

Q1: Concerns

One group felt it should be made clear who would be paying for medication, this being the patient themselves in the U.S.A. Another highlighted the possibility of mistakes and abusive coercion, pointing out this must exist in all end of life decisions, and claiming that this would actually involve less death than under current practices due to the heightened concerns for safeguards that would stem from PAS. The suggestion was that improved safeguards could be both protective of
self-determination and minimise the risks of premature death resulting from mistakes or abuse.

One group expressed worry of the stressful impact on practitioners and suggested that provision be made for counselling or other support for professionals involved.

Q2: Definitions

One suggestion was the assessment of competence should be carried out by either a Consultant Psychiatrist or a Consultant Clinical Psychologist. Another view was there was need for a specified plan for determination of capacity given it is the cornerstone of a request for PAS.

Q3: Reporting

One group suggested that the Member may want to include in the Bill specifics about the kind of information to be collected and when it’s collected during the process.

Q4: Time Period

It was suggested by one group that prognosis was difficult and that any timeframe would be arbitrary but six months was used in Oregon and this was consistent with regulations related to Hospice access.

Q5: Financial Burdens

It was pointed out that in the Oregon context federal money does and legally can not fund PAS and the State has to cover.

Q6: Further comments

Two groups stated positives about the Swiss experience. One described the situation there as well established and concerning a small number of patients, with a broad public and political support and no indications of a “slippery slope”. It was pointed out, though, that “suicide tourism” was one controversial aspect and consequence of PAS in Switzerland.

The other Swiss perspective urged that the taboo of the “good death” should be broached in our medical faculties. It was also stated that the Swiss penal code precludes anybody with a “selfish motive” from assisting in suicide.

In cultural terms another view on a par with the taboo reference was that Western culture contemplation about end of life was postponed by doctors and lay people because of fear of being confronted with their “inescapable exit”.

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One Dutch physician stated from their own experience: “It is very special to see how a patient, very dignified, as a captain of her/his own ship, surrounded by her/his family and completely aware of the situation, take leave of her/his once-only and most precious possession: life itself!”

Another doctor, though in support of the proposal, talked about the impact on them. “The task to end a patient’s life is a disturbing personal experience. It is emotionally very difficult. The doctor has to live with his own emotions. It is, and never will be, a routine medical practice. You take it home with you. It is a scar on your soul”.

Seven groups asserted that the “slippery slope” view was unfounded based on the experience in either Netherlands or Oregon. One group suggested that the “consequentialist considerations” proposed by those opposed to PAS (such as “slippery slope”, weakening of doctor–patient relationship, patients being pressured to request PAS etc) were not borne out by the data in either jurisdiction. One view was that “all too often the notion of a “slippery slope” is invoked without any logical basis or detailed analysis simply to shore up an otherwise inadequate argument”.

One doctor from the Netherlands, speaking from 50 year’s medical experience, suggested there to be no indication of the “slippery slope” nor any signs of discrimination or abuse of PAS against the elderly or disabled. He did acknowledge that “the attending physician” could sometimes come under pressure from patients not meeting the PAS criteria to help them die. However it was stated that legalised PAS prevents such illegal performances of the act and thus protects patients.

Another group asserted that 5 years of data and 16 years from Holland indicated stable take up levels for PAS and showed no pattern of abuse. It was added that the Oregon experience attested to the potential compatibility of improvements in palliative care and limited legal access to PAS.

One group pointed out that many patients request but never exercise the option of PAS but suggested all can experience a sense of “heightened autonomy” and peace of mind from knowing the choice exists.

One opinion was that we would be punished by the law if we kept an animal alive in similar physical conditions to some patients nearing the end of a terminal condition.

An American academic submitted an essay entitled “the Seven Deadly Sins of the Status Quo” and countering the arguments against PAS along the lines of: inhumanity (presently the option of dehydrating or starving to death is available); paternalism (based on a religious notion of you must suffer because it is good for you); utilitarianism (linked to the line that
palliative care must be improved and PAS is too easy for the health care delivery system and also variations of the slippery slope argument); hypocrisy (medical establishment knows it goes on now but turns a blind eye and wishes to protect members from bad publicity); lawlessness (mercy killings by family members reported in the press but likely more go unreported and undetected); injustice (regarding those who break the law to end suffering of patients or loved ones cannot expect equal treatment under the law); and the deadly risk of error and abuse (in terms of the legal system largely looking the other way when physicians and family assist in suicide).

The same respondent cited Oregon as “a living contradiction” of claims that PAS will lead to abuse and discrimination.

One group countered the argument of a negative impact on the doctor–patient relationship and suggested that since we’re talking about acceding to patients’ wishes that such a change may actually enhance that relationship.

A view on Oregon was that 6 years of experience showed no evidence to validate concerns raised prior to its implementation e.g. the law had not provided the opportunity for unscrupulous relatives to benefit from PAS requests or harried doctors to unload their burden.
Individual (miscellaneous)

This was the biggest section of the consultation categories with a total 356 submissions and making up 58% of the total response to the consultation. Respondents came mainly from Scotland but also from other parts of the United Kingdom. The majority responses were registers of support or opposition. In total there were 275 submissions of support (243 registers of support), 69 submissions of opposition (18 registers of opposition) and 12 submissions that remained neutral.

The level of interest from the general public suggests that the debate on Physician Assisted Suicide is welcomed, as is the highlighting of end of life issues.

Q1: Concerns

Several submissions were concerned that the proposed bill would not allow sufferers of debilitating illness i.e. MND the same treatment as those who are considered terminal. One respondent also believed that patients with dementia should also be included in the proposals.

Several submissions were concerned about health authorities being included in the ‘conscience clause’. One respondent believed that this may cause a disenfranchisement of parts of the population. Another believed it was vital that Health Authorities be compelled to participate to ensure that all patients can make use of the legislation. One respondent was concerned that the proposals would lead to ‘postcode’ dying with dignity, whereby only patients in certain areas would have access to physician assisted suicide.

Registers of support and opposition were mainly sentences stating the respondent’s position in relation to the proposed Bill.
One respondent raised their concern that, whilst supporting the Bill, it was important that it did not lead to a ‘License to Kill’. Another submission had concerns over the issue of next of kin and how the Bill would address this.

One respondent was concerned with the possible difficulties facing insurance provision for patients who request assistance to die. Another respondent questioned how a resident of Scotland would be defined under the Bill’s proposals.

Two submissions responded to this question only to say that they had no concerns with the proposals and that adequate safeguards appeared to be provided.

The trust between the doctor and patient was a concern raised a number of times by those in opposition to the Bill. As was the argument that many patients would come to feel like a burden if this option is made available to them. One respondent stressed that the legalisation of PAS would alter the whole ethos of the medical profession in Scotland.

One respondent believed the proposed Bill has connotations with the Abortion Act and would follow it’s example of a ‘slippery slope’. A further concern raised was that this Bill would take funding and resources away from palliative care services.

**Q2: Definitions**

The majority of responses believed the definitions to be acceptable. Some respondents however were concerned over the definition of adult and, specifically, with the eligibility of a 16 year old to make a request for PAS. One respondent suggested raising the age of consent to 18 and another suggested 21. A number of respondents had concerns that the definition of ‘capable’ was inadequate.

**Q3: Reporting**

Suggestions include:

- Local Health Authorities;
- District Health Boards who might collate annual reports which could then be consulted on;
- The Chief Executive of the NHS Board
- A Health Board Ethics Team
- Request forms should be passed to the Registrar of Deaths with regular reports being published;
- Scottish Executive Health Department;
- An ad hoc committee of local General Medical Councils;
- An independent organisation (specifics not included)
- Two submissions stated the Public Guardian;
- The Health Department, as in the Oregon example, and open to public viewing;
- Two submissions believed reporting must be administered by someone of the medical profession and involved in the patient’s care.

Q4: Time period

Several submissions questioned why there should be any delay between the diagnoses and a patient’s request. Two respondents believed that the entitlement to request physician assisted suicide should come at any time after the diagnosis has been made. A further two respondents stated that there should be no time period set as each case is so individual and prognosis can be so uncertain. A further response argued that it was the patient’s choice and that entitlement should be given to them when their quality of life has gone. Several respondents believed there should be no such restriction whilst others argued that this was necessary to ensure safeguards were put in place.

A number of respondents were also concerned about the need for a written request to die, especially in cases where a patient is no longer able to write. Some suggested the use of a tape recorder as an alternative.

One submission believed there should be a 3 month period between diagnosis and entitlement to request PAS.

One submission believed that, following diagnosis, at least 48 hours should be allowed between the 1st and 2nd requests by the patient to die. This respondent further believed that the provision of Physician Assisted Suicide should depend also on levels of unbearable pain rather than length of prognosis.

Another submission stated that assisted suicide should be available to those who have been diagnosed to die within 6 months and, from the day of diagnosis, the patient should be entitled to make their decision within 48 hours.

One respondent argued that, within hospice circles, the dying process is considered as the patient being in their last 48 hours of life. Terminal illness on the other is diagnosed as less than 6 months to live in alignment with fulfilling the DS1500 form3

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3 A medical report relating to a terminally ill patient’s condition – The DS1500 is required so that a patient may make a claim for Disability Living Allowance or Attendance Allowance
Another response believed that setting a timescale may make the patient feel rushed into making a decision.

The unpredictability of diagnosis was agreed by several respondents. One respondent called for more clarification of diagnosis and which illnesses would be included, especially in cases of degenerative illness such as MND.

Q5: Financial Burden

Responses in support of the proposals included the following suggestions:

- Mostly administrative costs;
- All costs should be met by the applicant;
- Seven submissions believed there would be no financial burden but would in fact save the NHS costs on unwanted, expensive treatments
- Small financial repercussions
- Necessary use of another doctor could involve some expense which some patient’s may be willing to pay themselves.

Responses in opposition to the proposals made the following arguments:

- Two respondents believed that this legislation would lead to a redirection of funding away from palliative care services. One believed this would be because palliative care services would be needed progressively less, and the other because any new system or service would be expensive to set up and as such resources would need to be diverted;
- This was backed up by another response which claimed that costs would be reduced as good palliative care will always be more expensive than offering PAS service;
- One submission stated that the NHS must first concentrate on ‘assisted living’ of disabled people before funding is provided for ‘assisted dying’;
- One respondent was concerned about the financial implications on hospices and their ability to maintain charitable status.

The neutral submissions stated that this legislation must be adequately funded to ensure that all safeguards are put in place and adhered to. They further commented that, on balance, it was perceived that no financial burdens would arise from the proposals.

Q6: Further comments

The main arguments of support expressed in this section include:
- That religious affiliations should have no bearing on legislation of this kind;
- That individuals should have a personal choice when it comes to their death;
- That it is inhumane to keep someone alive when they wish to die;
- That patients should have greater choice at the end of their lives;
- That current law is inconsistent and there is a need to create a properly regulated system that would ensure safeguards are in place and protect the vulnerable from abuse;
- That animals are not expected to suffer when nearing the end of their life so humans should have the same right;

The main arguments of opposition in this section include:

- That legislation to allow Physician Assisted Suicide will create a slippery slope, or thin edge of the wedge, leading to legalised euthanasia;
- That no one has the right to end another person’s life;
- That more help should be given to hospice care and that this legislation will redirect palliative care resources;
- That it will undermine the doctor-patient relationship and create mistrust between them;
- That this legislation would be open to abuse and that safeguards could prove inadequate;
- That terminally ill patients would be made to feel like a burden;
- That prognosis and diagnosis are fallible;
- That this legislation goes against the Hippocratic Oath and;
- That there is no right to die and that the right to life is inalienable.
Conclusions

This proposal has produced an enormous amount of interest and the sheer volume of response reveals that this is clearly a matter of significance to Scotland’s society. The right to die and the concept of Physician Assisted Suicide are emotive topics and there is no denying the strength of feelings that surround the debate.

The views expressed in response to this consultation have come from all sections of our society. It is clear that some sections do not support a change in the law; however it is also clear from these results that a great many individuals in Scotland support the Bill as it currently stands. A total 346 out of the 616 submissions supported the Bill, accounting for a majority 56 per cent. This report therefore concludes that there is strong support for a change in the law in Scotland to allow a mentally capable, terminally ill adult the right to receive medical assistance to die.

This report further concludes that the concept of ‘choice’ was widely supported by a majority of respondents. This is significant as the proposed Bill would provide the opportunity of an additional ‘choice’ to terminally ill patients as they near the end of their life. The proposed legislation would be an alternative; an option to those who requested it and, equally, it would be the patient’s right to refuse this course of action if they so chose.

A further argument that was raised by those who supported the Bill was that of the need for regulation and safeguards to prevent current practice of ‘underground’ euthanasia. Some respondents argued against this line stating that there was no evidence of any such underground activity in Scotland. However this was refuted by others who argued that there was no way of knowing what the current practice was as there was no means of monitoring it. It was further argued that any incidents of assisted dying in this country were inevitably unreported due to the current inconsistencies and indistinct nature of the legal situation. Many respondents believed that this Bill would be useful in creating a properly regulated system, with clearly defined legal parameters; ensuring safeguards were put in place to protect the vulnerable from abuse.

Additional arguments in support of the Bill included the view that, in the case of a terminally ill adult, it is the humane and moral thing to do to help them when they have requested assistance to die. A number of respondents also raised the point that animals in our society are not expected to suffer at the end of their life and, in fact, it is considered cruel to allow them to suffer. As such it was argued that humans should not be denied a right that is already granted to animals. Another line of argument was that patient’s should have more personal choice when it
came to their death. Finally several submissions argued that religion and religious affiliations should have no bearing on this legislation. The British Humanist Association further argued that was specifically the case in today’s more secular society where there are an increasing number of atheists and agnostics who have no religious belief.

Whilst this analysis reveals that a majority of respondents supported the Bill, there were a good number who were opposed to it. Of the total 616 responses 201 submissions were made in opposition to the Bill, equating to 33 per cent of the overall response. Of the twelve sections considered in this report, five showed a majority opposition to the proposals. These included Religious Organisations, Palliative Care Groups, Medical Bodies, Pro-Life Interest Groups and Individual Medical Staff. These are significant sectors of society and also include those bodies and individuals who would be required to be actively involved were this Bill to become law.

The main reason for the opposition from Religious Organisations was their belief that the sanctity of life was absolute and that life was God-given. Any attempt therefore to take away life, or to assist in that act, could be perceived as acting God and was therefore to be refuted. This was a common theme from the majority Christian denominations as well as the Catholic Church and the Council of Jewish Communities. The only religious organisation to differ from this view was the Baha’i Council of Scotland which remained neutral in its submission stating that there was nothing in their Sacred Scriptures that spoke against the concept of a right to die and, as such, any decision should be made by the individual.

The Pro-Life Interest Groups supported the view from religious organisations that life was sacred. The main argument expressed from this section was that the right to life is inalienable and it is the duty of the State to protect that right for all citizens. One interest group argued that the proposed Bill would take that protection away from a small number of people and often at a time when they would be most vulnerable. This section further argued that there is no right to die and that this is supported by Article 2 of the European Convention on Human Rights which states that “Everyone's right to life shall be protected by law”.

The right to life was a recurring issue that was further raised by a number of individual medical staff. This section was mostly concerned that the proposed Bill would undermine the role of the medical profession and that it would be contrary to the Hippocratic Oath to ‘First Do No Harm’. The majority of respondents in this section were concerned that the proposals would fundamentally alter their role in society, not least because of the affect it would have on the relationship between them and their patients. The issue of trust was a regular theme and the case of Harold Shipman was often mentioned or used as example. A number of respondents were concerned that the proposed Bill would turn their
profession into *killers* as opposed to *healers*. One respondent believed that the Bill would attract the ‘wrong sort’ of person to work in the NHS and would result in a *Shipman Shadow* over the health service. Furthermore a number of respondents were concerned that the Bill, if it became law, would put an extra burden on a dying patient. It was argued that many elderly patients already feel like a burden due to the financial and emotional difficulties in providing their care and that, as a result, many would choose to request assistance to die.

The responses from this section also outlined more specific areas that were believed needed further consideration, such as the types of drugs used, the legal position of a carer and the role of pharmacists. Most specifically the majority of medical respondents expressed their concern that the Bill’s proposals would allow a terminal ill patient ‘diagnosed with 6 months or less to live’ the right to request assistance to die as the uncertainty of diagnosis and prognosis was notorious. The unreliability of diagnosis was an argument also supported by a number of respondents from the Palliative Care sector.

The main argument expressed in opposition to the Bill from Palliative Care Groups and staff was that dying with dignity already occurs through the provision of palliative and hospice services. A large majority of respondents believed that the title of the consultation was misleading and should have been titled “Assisted Dying” or “Medicine Assisted Death” to avoid any connotation with dignity. One respondent argued that *death with dignity* is what good palliative care is all about; it is a holistic service providing both medical and emotional support at the end of life. A major concern raised by this group of respondents was that the proposed Bill would take funding and resources away from palliative care services. Several submissions believed that palliative care would be neglected as PAS could be considered an ‘easy option’ and also the ‘cheaper option’. The Scottish Partnership for Palliative Care, whilst expressing its opposition to the Bill for these reasons stated above also acknowledged however that, for a small number of individuals, *the existential and physical suffering for the dying process will not be relieved by palliative care and that the issue of satisfactorily caring for these individuals should be addressed.*

It should also be noted that a number of palliative care staff and organisations welcomed this proposal as a means of opening up the debate into end of life care.

These arguments of opposition were also voiced by a number of medical bodies, particularly a number of the Royal Colleges. However it should also be noted that several medical bodies, including the British Medical Association (confirmed after the consultation period ended), have stated their neutrality to the Bill’s proposals. The BMA has stated that *the*
question of the criminal law in relation to assisted dying is primarily a matter for society and for Parliament.

There were a further 67 submissions which were of a neutral position to the proposals, equating to 11 per cent overall. The majority of NHS Boards and Local Authorities that responded remained neutral, as did the majority of responses made from academics and international submissions.

The following section outlines this report's suggestion for items requiring further consideration.
Items for further consideration

Health Boards

A major theme to have arisen from the responses to the consultation was the issue of the ‘conscience clause’; the provision in the legislation to allow a doctor or health care authority to opt-out from participating in the Act if they conscientiously objected. A large number of respondents were concerned that Health Boards would not be compelled to participate and that this would lead to discrimination. Many believed it would result in a ‘postcode lottery’ whereby patients in certain health board areas could not request assistance to die because their local health board had chosen to ‘opt-out’. This was perceived to be both discriminatory and would lead to inequity of care depending on where you lived.

Implications on insurance

A further item for consideration is the implications this proposal would have on insurance. A number of respondents were concerned that the consultation stated that the Bill could not make insurance provision due to this being a reserved issue and queried how this would then be resolved.
## Appendix A: list of respondents

### NHS Boards

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>NHS Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Stella Clark</td>
<td>Acting Medical Director</td>
<td>NHS Fife</td>
</tr>
<tr>
<td>Dr Gordon Peterkin</td>
<td>Medical Director – Cross System</td>
<td>NHS Grampian</td>
</tr>
<tr>
<td>Dr I W Wallace</td>
<td>Medical Director – Primary Care Division</td>
<td>NHS Greater Glasgow</td>
</tr>
<tr>
<td>Phil Mackie</td>
<td>Senior Specialist in Public Health</td>
<td>Lothian NHS Board</td>
</tr>
<tr>
<td>Professor George L Irving</td>
<td>Chairman</td>
<td>NHS Argyll and Arran</td>
</tr>
<tr>
<td>Neil Agnew</td>
<td>Chairman</td>
<td>NHS Lanarkshire</td>
</tr>
<tr>
<td>Di Norris</td>
<td>Clinical Ethics Committee</td>
<td>NHS Highland</td>
</tr>
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### Local Authorities

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<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Alan G Campbell</td>
<td>Chief Executive</td>
<td>Aberdeenshire Council</td>
</tr>
<tr>
<td>Janet Birks</td>
<td>Director of Housing and Social Work Services</td>
<td>Falkirk Council</td>
</tr>
<tr>
<td>Miss M A B Sutherland</td>
<td>Senior Executive Officer</td>
<td>Orkney Islands Council</td>
</tr>
<tr>
<td>Jim Dickie</td>
<td>Director of Social Work</td>
<td>North Lanarkshire Council</td>
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</table>

### Medical Bodies:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Body</th>
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<tbody>
<tr>
<td>J A R Smith PhD PRESEd FRCSEng</td>
<td>President</td>
<td>The Royal College of Surgeons, Edinburgh</td>
</tr>
<tr>
<td>Patricia Dawson</td>
<td>Head of Policy Communication</td>
<td>Royal College of Nursing Scotland</td>
</tr>
<tr>
<td>Ben Collins</td>
<td>Scottish Affairs Officer</td>
<td>GMC Scotland</td>
</tr>
</tbody>
</table>
Dying with dignity consultation

Professor Graham M Teasdale
President
Royal College of Physicians and Surgeons of Glasgow
Parliamentary Coordinator
Disability Rights Commission

Euan Page
Consultant Paediatrician
Royal College of Paediatrics and Child Health (Scotland)

Peter Smail
Senior Public Affairs Officer (Scotland)

Gail Grant
SHO in Psychiatry
Scottish council on Human Bioethics member

Dr T Everett Julyan
Christian Medical Fellowship member
Director of Research

Dr Calum MacKellar
Scottish Council on Human Bioethics Honorary Secretary
Royal College of Physicians and Surgeons of Glasgow

Dr P V Knight
Team Leader
Fellowship Support Unit

Lesley Lockhart
PR Administrator
Royal College of General Practitioners Scotland

Susannah Lane
Royal College of Physicians of Edinburgh

Dr Peter Simpson MD FRCA
President
The Royal College of Anaesthetists
Scottish Division Manager

Karen Addie
The Royal College of Psychiatrists

Palliative Care Groups

Name
Angela Bradshaw
Dr Jim Rodgers

Dr David Jeffrey FRCP(Edin), FRCP
Catriona Ross MB ChB FRCP
Sheila Cowe
Dr J Martin Leiper
Mary Shields

Position
Hospice
Consultant in Palliative Care
Chairman of The Ethics Committee
Executive Committee Member of the Association for Palliative Medicine of GB & Ireland
Consultant in Palliative Care
St Andrew’s Hospice
Palliative Care Specialist Nurse
Consultant in Palliative Medicine
NHS Tayside
Hospice Physician
Dying with dignity consultation

Jackie Husband
Dr Duncan Brown
Dr Kirsty Boyd
Dr Derek Doyle OBE
Susan Dillet
Dr T. F. Benton
A
Kate Lennon
I
Janet Trundle
Joan Adam
Dr Sheila McGettrick
Pauline Britton
Christa Wynn-Williams
Paula McCormack
Jeremy Keen
Maria McGill
Stephen Hutchison
Derek C Blues
Dr Sarah Miller MBChB, MRCP (UK)
Dr Mhoira Leng

Medical Staff (Individual)

Name
Amy Briffa
Andrew Bathgate

Position
Medical Student
Physician
Dying with dignity consultation

Anne Savage
Royal Infirmary of Edinburgh
retired GP

Margaret Mitchell
Macmillan Nurse Specialist
Argyll

Brenda McGregor
Retired Nurse

Bruce Turner
Clinical Nurse Specialist

C
Macmillan Nurse Specialist

Katie Naysmith
Dunoon

C.A.B. Johnston
Retired Surgeon

Carole Evans
Staff Nurse

Catherine McDougal
Clinical Lecturer

Claire Elder
Royal Aberdeen Children’s Hospital

D
4th Year medical student

Irene MacPherson
University of Edinburgh

D.A Maclean FRCS Ed.
District Nurse

David Dorward
Inverclyde

David F Abbott MD MRCP
Retired Consultant General Surgeon

Dr A B Cooper
4th Year medical student

Dr Anne Williams
University of Edinburgh

GP

GP

GP

NHS GP

Dr Bruce Cleminson
Scalloway, Shetland

FRCGP

Macmillan GP for Shetland

Dr C Urquhart
Culloden Surgery

Dr C Chancellor
GP and Community Hospital Doctor

Dr J Alexander
Doctor/Heart Failure specialist

Dr Charles L Crichton
Emeritus Consultant

Dr Christopher Ward
St Mary's Hospital

Dr Clive Tonks
London

Retired GP

Dr David Murray
Senior House Officer, Psychiatry

No Name

Medicine for the Elderly

Dr Graeme Simpson
Royal Alexander Hospital

Dr Jack A Macfie
NHS GP

Dr James D M Douglas MD
GP
### Dying with dignity consultation

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Jeffrey Garland</td>
<td>Honorary Consultant</td>
<td>Oxfordshire Mental Trust</td>
</tr>
<tr>
<td>Dr Lesley Hall MBChB MRCP(UK)</td>
<td>Hospital Doctor</td>
<td></td>
</tr>
<tr>
<td>Dr Lorna Nunn</td>
<td>GP</td>
<td></td>
</tr>
<tr>
<td>Dr Mary T Jordon</td>
<td>GP</td>
<td></td>
</tr>
<tr>
<td>Dr Nick Hallam</td>
<td>Consultant Virologist</td>
<td></td>
</tr>
<tr>
<td>Dr Peter Hutchison</td>
<td>ERI</td>
<td></td>
</tr>
<tr>
<td>Dr Peter Kiehlmann</td>
<td>GP</td>
<td>Danestone Medical Practice</td>
</tr>
<tr>
<td>Dr Peter Kiehlmann</td>
<td>Group of 8 GP trainers</td>
<td>Aberdeen</td>
</tr>
<tr>
<td>Dr Rebecca Goody</td>
<td>Senior House Officer</td>
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<tr>
<td>Dr Sarah Ross</td>
<td>GP</td>
<td></td>
</tr>
<tr>
<td>Dr T. M Shallcross</td>
<td>NHS consultant physician and geriatrician</td>
<td></td>
</tr>
<tr>
<td>Dr Tricia Kiehlmann</td>
<td>GP</td>
<td></td>
</tr>
<tr>
<td>Dr William Whiteley</td>
<td>Specialist Registrar in Medical Neurology</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Macmillan Nurse Specialist</td>
<td>Mid Argyll</td>
</tr>
<tr>
<td>Angela Bradshaw</td>
<td>Nurse</td>
<td>Stoma Care Department Southern General Hospital</td>
</tr>
<tr>
<td>Edward Pringle</td>
<td>GP</td>
<td></td>
</tr>
<tr>
<td>Elizabeth Graham</td>
<td>GP in Kirkintilloch</td>
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<tr>
<td>Elizabeth Swaine</td>
<td>Member of CMF</td>
<td></td>
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<tr>
<td>Eric Mackay</td>
<td>Retired GP</td>
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<tr>
<td>F</td>
<td>Fellow of the College of General Practitioners</td>
<td></td>
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<tr>
<td>Diane Sinclair</td>
<td>GP</td>
<td>Tighnarbruich</td>
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<tr>
<td>Fiona Mackay</td>
<td>GP</td>
<td>Medical Student</td>
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<tr>
<td>G M Douglas Scott BA MPH</td>
<td>People Consultant/Counsellor</td>
<td>Macmillan Nurse Specialist</td>
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<tr>
<td>PGCE PGDipCouns</td>
<td></td>
<td>Islay</td>
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<td>G</td>
<td>Consultant Surgeon</td>
<td>Gilbert Bain Hospital</td>
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<tr>
<td>Jennifer Aitchison</td>
<td>GP</td>
<td>Lerwick</td>
</tr>
<tr>
<td>Gordon A McFarlane ChM FRCS</td>
<td></td>
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</tr>
</tbody>
</table>
Dying with dignity consultation

H
Eleannor Hodgson
GP
Paisley
4th Year medical student
University of Edinburgh
Hannah Bainbridge
Hospital Chaplain
Queen Mother’s Hospital
NHS Greater Glasgow
Hilda C Smith
J
Staff of Lomond LHCC
Clinical Forum
John Dorward
Kathleen Doherty
Ken Smith
Linda Murray
Marianne Macleod
Michael Wilson
Mr Keith Buchan
Mr Tony Fitzpatrick
Mrs Linda Cliff
Mrs Morag A Buchan
Mrs Wilma Brown RGC
ONC
Ms Jane McMaster
Peter Bruggen
Professor Bryan Jennett
CBE MD FRCS
Professor R. S. Downie
R. M. Kalbag
Rachel Hatherley
Ronald Douglas
Ross Macdonald
Sonia MacCallum

G
Patient and Family Support Nurse
nurse
Cancer Information Liaison Nurse
Roadmeetings Hospital
NHS Lanarkshire
Staff Nurse
GP
Consultant Surgeon
Aberdeen Royal Infirmary
Carer
NHS Lanarkshire
Community Macmillan Nurse
Shetland
(personal views from 3 medical and 2 nursing staff)
Nurse
Former Nurse
retired psychiatrist
Emeritus Professor of Neurosurgery
Glasgow University
Emeritus Professor of Moral Philosophy
Glasgow University
Retired Consultant Neurosurgeon
Student Nurse
retired GP
4th Year medical student
University of Edinburgh
Final Year Student
Edinburgh Medical School
Stuart Ferguson  
Medical Student  
Glasgow University  

Teresa McNally  
Former Nurse  

Thomas Thorp  
4th Year medical student  
University of Edinburgh  

**Religious Organisations**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>John F Stuart</td>
<td>Secretary General</td>
</tr>
<tr>
<td>Free Presbyterian Church of Scotland</td>
<td>Clerk of the Religion and Morals Committee</td>
</tr>
<tr>
<td>Rev Angus Smith</td>
<td>Christian Convenor of Committee on Public Questions</td>
</tr>
<tr>
<td>Anne Murray</td>
<td>Free Church of Scotland Clerk</td>
</tr>
<tr>
<td>D W Matheson</td>
<td>Presbytery of Ayr Church of Scotland</td>
</tr>
<tr>
<td>Dr I McD Jessiman</td>
<td>member of the Guild of Catholic Doctors General Director</td>
</tr>
<tr>
<td>Rev William G Slack</td>
<td>Baptist Union of Scotland</td>
</tr>
<tr>
<td>Max Ramsay</td>
<td>retired Church of England Priest Church of Scotland</td>
</tr>
<tr>
<td>Agnes Llano</td>
<td>Board of Social Responsibility Secretary</td>
</tr>
<tr>
<td>Isobel Berks</td>
<td>Nurses Christian Fellowship of Scotland</td>
</tr>
<tr>
<td>Pat (no surname provided)</td>
<td>Scottish Catholic Assistant to the Scotland Secretary</td>
</tr>
<tr>
<td>Alan Dixon</td>
<td>The Salvation Army Policy and Equalities Officer</td>
</tr>
<tr>
<td>Vanessa Taylor</td>
<td>Scottish Inter Faith Council Public Affairs Officer</td>
</tr>
<tr>
<td>Douglas A Yates</td>
<td>The Church of Jesus Christ of Latter–day Saints</td>
</tr>
<tr>
<td>Thomas A Magill</td>
<td>St George’s – Tron Parish Church</td>
</tr>
<tr>
<td>John Deighan</td>
<td>Catholic Parliamentary Office</td>
</tr>
<tr>
<td>Liz Carty</td>
<td>Social Care Commission of the Archdiocese of St Andrews and Edinburgh</td>
</tr>
<tr>
<td>Rev. David Lunan</td>
<td>Presbytery Clerk</td>
</tr>
<tr>
<td>Rev. David Lunan</td>
<td>Glasgow Presbytery</td>
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</table>
Helen Milburn  
Member of the Lawyers Christian Fellowship

Dr Nick Hallam  
Christian Medical Fellowship

Dr Peter Kiehlmann  
Macmillan Lead Cancer GP  
Pastor

Matthew Henderson  
Gerrard Street Baptist Church  
On behalf of the Baha’i Council for Scotland  
Chairman

Carrie Varjavandi  
On behalf of the Baha’i Council for Scotland  
Chairman

Murray McCheyne  
Lawyers Christian Fellowship  
(personal response)  
Public Affairs Officer

Leah Granat  
Scottish Council of Jewish Communities

Rev. Robert Currie  
Retired Community Minister  
Parliamentary Officer

Jeremy R Balfour  
Evangelical Alliance Scotland

Leo Glancy  
Parish Priest  
Oxnam Parish Church

Damon Rodwell  
Roxburghshire

‘Neutral Groups’

<table>
<thead>
<tr>
<th>Name</th>
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</thead>
<tbody>
<tr>
<td>Mr Colin Dalrymple</td>
<td>General Secretary</td>
</tr>
<tr>
<td>Professor Alice Brown</td>
<td>Ombudsman</td>
</tr>
<tr>
<td></td>
<td>Member of the City of Edinburgh Older Peoples Equality Forum Health Sub Group</td>
</tr>
<tr>
<td>Mr W. R Macrae</td>
<td>Development Manager</td>
</tr>
</tbody>
</table>
| Margaret Moncrieff          | North Lanarkshire Carers Together  
Honorary Secretary        |
| Brendan J Martin            | British Geriatrics Society (Scotland)  
Director                |
| Michael P Clancy            | Law Society of Scotland  
Chief Executive         |
| Craig Stockton              | Scottish Motor Neurone Association  
Caring Services Manager, Scotland |
| Susan Munro                 | Marie Curie Cancer Care  
NOSCAN Manager           |
| Paul Welford                | North of Scotland Cancer network                             |
| Cath O’Brien                | Health Policy and Campaigns Officer                           |
| Gordon Macdonald            | Parkinson’s Disease Society for the UK                        |
|                             | CARE for Scotland                                            |
Dying with dignity consultation

Pro–Physician Assisted Suicide Interest Groups

Name                  Position                                      
Mr John Raven         VES member                                
N. W. J. Henney       VES member                                
Hanne Stinson         The British Humanist Association            
                      ex–Chairman of the VES in England and Wales     
Mr Michael Irwin MB BS MPH       ex–President of the World Federation of Right-to–Die Societies 
Anne Horner           Lib Dems 4 Patient Choice                     
Sue Tritton           VESS member                                
Stella Ciorra         VES member                                
Nigel and Judy Collins VES members                             
Margaret Jackson      TVES member                               
Peter Rainer           VES member                                
Jill Howlett           VES member                                
Robert H E Brown      VES member                                
Gillian Kisch         VES member                                
Ivan Martin            VES member                                
Niall and Nancy Rudd  VES members                               
Jennifer Bate          VES member                                
Gloria Thomson        VES member                                
Lisa Cook              UKActNow.org                              
Elise Atkinson        VES member                                
Anne Taute            VES member                                
Thomas A McAllister   VESS (EXIT) member                         
Cheri Lloyd           VES member                                
Chrissie Wright       member of Friends at the End                 
J. D. Mellor          VES member                                
Ms A. Clunas          member of Friends at the End                 
Charles Douglas       Humanist Society of Scotland                  
Libby Wilson          FATE                                      
Keith Reed            Voluntary Euthanasia Society

Pro–Life Interest Groups
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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</thead>
<tbody>
<tr>
<td>Dr R. Lamerton / E. Chowdhary-Best</td>
<td>ALERT – Against Legalised Euthanasia</td>
</tr>
<tr>
<td>Mrs Deanna McQuae</td>
<td>SPUC newsletter</td>
</tr>
<tr>
<td>J J Casca Rimo</td>
<td>SPUC newsletter</td>
</tr>
<tr>
<td>Mrs M Semple</td>
<td>SPUC newsletter</td>
</tr>
<tr>
<td>Mr Dermot O’Sullivan</td>
<td>SPUC newsletter</td>
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<tr>
<td>Teresa Macneil</td>
<td>SPUC newsletter</td>
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<tr>
<td>Mrs Mary F MacKinnon</td>
<td>SPUC newsletter</td>
</tr>
<tr>
<td>Mrs Elain Gallacher</td>
<td>SPUC newsletter</td>
</tr>
<tr>
<td>Mr John Tighe</td>
<td>SPUC newsletter</td>
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<tr>
<td>Margaret &amp; Helen Fisher</td>
<td>SPUC newsletter</td>
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<tr>
<td>Patricia McNee</td>
<td>SPUC newsletter</td>
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<tr>
<td>Mr Peter Cairns</td>
<td>SPUC newsletter</td>
</tr>
<tr>
<td>Mary Rocchicioli</td>
<td>SPUC newsletter</td>
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<tr>
<td>Agnes Girvan</td>
<td>SPUC newsletter</td>
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<tr>
<td>Mrs Margaret Reilley</td>
<td>SPUC newsletter</td>
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<tr>
<td>Mr M Doherty</td>
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<tr>
<td>Dr Mary Knowles FFARSCI</td>
<td>Chair First Do No Harm (action group on euthanasia)</td>
</tr>
<tr>
<td>Catherine O’Sullivan</td>
<td></td>
</tr>
<tr>
<td>M. McCauley</td>
<td>SPUC newsletter</td>
</tr>
<tr>
<td>Mrs M. B. Kobylarska</td>
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<tr>
<td>Cath Stainsby</td>
<td>SPUC newsletter</td>
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<tr>
<td>Isobel Bray</td>
<td>SPUC newsletter</td>
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<tr>
<td>Mrs Rose Grant</td>
<td>SPUC newsletter</td>
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<tr>
<td>Julia Millington</td>
<td>Political Director</td>
</tr>
<tr>
<td>Jaqueline F Dalrymple</td>
<td>ProLife Alliance</td>
</tr>
<tr>
<td>William, Gertrude &amp; Trevor</td>
<td></td>
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<tr>
<td>Paul Docherty</td>
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<td>Bill Stainsby</td>
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<tr>
<td>Ian Murray</td>
<td>Director Society for the Protection of Unborn Children (SPUC)</td>
</tr>
<tr>
<td>Anne Murray</td>
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<td>Anne Parker</td>
<td>SPUC newsletter</td>
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<tr>
<td>Mrs Mary Lipton</td>
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</tr>
<tr>
<td>Academic</td>
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## Name and Position

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Mrs I Paterson</td>
<td>Lecturer in Health Care and ethics</td>
</tr>
<tr>
<td>Dr Tuija Takala &amp;</td>
<td>Lecturer in Bioethics &amp; Adjunct Professor</td>
</tr>
<tr>
<td>Professor John Harris</td>
<td>in Practical Philosophy</td>
</tr>
<tr>
<td>Dr John Shand</td>
<td>Associate Lecturer in Philospohy</td>
</tr>
<tr>
<td>Professor Sheila A. M.</td>
<td>The Open University</td>
</tr>
<tr>
<td>McLean</td>
<td>University of Glasgow</td>
</tr>
<tr>
<td>Dr Stephen W. Smith</td>
<td>Lecturer of Law</td>
</tr>
<tr>
<td>Dr Tom Shakespeare</td>
<td>University of Birmingham</td>
</tr>
<tr>
<td>Professor John Hick</td>
<td>Sociologist</td>
</tr>
<tr>
<td>Prof J.H McKillop</td>
<td>University of Newcastle</td>
</tr>
<tr>
<td>Dr Pawel Niewczas</td>
<td>University of Birmingham</td>
</tr>
<tr>
<td>Janis Moody</td>
<td>Head of Undergraduate Medical School</td>
</tr>
<tr>
<td>Mary Ford</td>
<td>Institute for Energy and Environment</td>
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<td></td>
<td>University of Strathclyde</td>
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<td></td>
<td>School of Acute and Continuing Nursing</td>
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<td>Napier University</td>
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<td></td>
<td>Lecturer in Law</td>
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<td>University of Nottingham</td>
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## International

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Georg Bosshard MC MAE</td>
<td>Institute of Legal Medicine</td>
</tr>
<tr>
<td>Gerald Dworkin</td>
<td>University of Zurich</td>
</tr>
<tr>
<td>Aycke O A Smook</td>
<td>Professor of Philosophy and Law</td>
</tr>
<tr>
<td>Henk–Maarten Laane MD</td>
<td>University of California</td>
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<tr>
<td>PhD MAS</td>
<td>Surgeon–Oncologist</td>
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<tr>
<td>G. van Geldrop MD</td>
<td>Member of Dutch Society of Voluntary Euthanasia</td>
</tr>
<tr>
<td>Professor John Griffiths</td>
<td>Member of the World Federation Right to Die Societies</td>
</tr>
<tr>
<td>Barbara Glidewell MBS CEC</td>
<td>Dutch GP</td>
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<tr>
<td>C–PtAdv</td>
<td>Consultant to the Dutch Court on Euthanasia</td>
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<tr>
<td></td>
<td>Dutch GP</td>
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<tr>
<td></td>
<td>SCEN–physician</td>
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<tr>
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<td>Department of Legal Theory</td>
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<td></td>
<td>University of Groningen</td>
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<td></td>
<td>Ombudsman and Director</td>
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<td></td>
<td>OHSU Dept. of Patient Relations</td>
</tr>
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<td>Oregon</td>
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</table>
Dying with dignity consultation

Timothy Quill
Professor of Medicine, Psychiatry and Medical Humanities
University of Rochester, NY
Secretarial Staff

Elisabeth Leresche
EXIT ADMD SWITZERLAND
EUROSUPPORT
Prone Leopold Insitute for Tropical Medicine

Veronica Van Wijk
Belgium
co–CEO
Compassion and Choices (previously Compassion in Dying)

Barbara Coombs Lee
Oregon, USA
CEO

Rob Jonquiere
NVVE (Dutch Right to Die)

Ranjan and Linda Ray
Perth, Australia
Professor of Philosophy

David J Mayo, PhD
University of Minnesota
Professor of Law

Charles H Baron
Boston College Law School
Professor of Psychology

R Glynn Owens
University of Auckland
Department of Psychology

Dr James L. Werth
Ohio
General Practitioner
SCEN-arts

Sytske van der Meer
The Netherlands
Medical Director
Allegheny County Office of Behavioural Health
Pittsburgh

Wesley Sowers MD
PA 15222
Church of Scotland

Rev Phil Garretty
Bermuda

Individual (miscellaneous)

A S Fraser
Keery Peckover
A Wills
Keith Bell
Adam Bolland
Keith Smith
Adam English
Ken Mines
Agnes Wilson
Kevin Dillon
Alan and Eluned Sproat
Kirsten Cassidy
Alan Beattie
Kirsty McKnight
Alan Westwood
Krish Roy
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<td>Libby Dicken</td>
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<td>Louise Kendall</td>
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<td>Lynn Murray</td>
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<td>Alison ter Haar</td>
<td>M. A. Wongherty</td>
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<td>Andrew Tebbutt</td>
<td>Mandie (surname unknown)</td>
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<td>Andrew W Kepherr BA</td>
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<td>Margaret Rowe</td>
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<td>Ann Mckechin MP</td>
<td>Margaret Ryman</td>
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<td>Marriane White</td>
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<td>Mary Durroch</td>
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<td>Mary Dysko</td>
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<td>Bob and Joan Aspley</td>
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<td>Mary McParlend</td>
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<td>C B Galloway</td>
<td>Maureen McEvoy</td>
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<td>Carole Bent</td>
<td>Maya Chatterjee</td>
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<td>Carole Cleverdon</td>
<td>Michael and Janice Sharples</td>
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<td>Carole Green</td>
<td>Michael Calwell</td>
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<td>Catherine A Greenless</td>
<td>Michael McDonald</td>
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<td>Catherine Gent</td>
<td>Michael S Beattie</td>
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<td>Catherine Mainland</td>
<td>Michael Sheetiam Esq.</td>
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<td>Catherine McDermott</td>
<td>Michael Taylor</td>
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<td>Cathy Crawford</td>
<td>Michal Charley</td>
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</table>
Dying with dignity consultation

Catriona McIntosh
Chris Gillings
Cllr A Marsh
Cllr Barry Phelps
Cllr Chris Thomas
Cllr Kate Smith
Cynthia Cummins
D. Daly
Dave Morrison
David and Kathryn Gordon
David and Katie Airlie
David and Rosemary
Arthur
David Cargin
David Cunningham Green
David Curtis
David D MacFarlane
David Donnison
David Leighton
David Norczyk
David Osorio
David Partridge
David Sloan
David Springhall
Dawn Dolphin
Debbie MacKinnon
Deirdrie O'Reilly
Dennis Cox
Derek Gladwell
Derek Jakes
Diana Blackwell
Diane Barker
Don Aston
Donald Fleming
Donald Thackeray
Doreen E MacWhannell
Dr Anne M Urquhannell
Dr C McCraw
Dr David Gould
Dr Eleanor Burt
Dr Euan Dodds
Dr Jenny Dixon

Michelle Laing
Mike Meenan
Mike Winsborrow
Miriam Losupovicici
Miss Dorothy L Forrester
Miss Karen Macarthur
Miss Madeleine Birch
Miss Margo Logie
Miss Tina Olson
Miss Voilet Laidlaw
Mo Templeman
Moira Clayton
Moira Giddens
Moira Hope
Montse Baste
Moray Paterson
Mr & Mrs H McCue
Mr Bernard M. Lindberg
Mr M Newman
Mr Michael Doig
Mr MR Pillar
Mr Robert Thomson
Mr William McIntosh
Mr Willie Saynor
Mrs C Stubbs
Mrs Carmelle James
Mrs Catherine Gurney
Mrs Eleanor Appleby
Mrs Elizabeth Wade
Mrs F. H. Greenlaw
Mrs G Brophy
Mrs J Greenhorn
Mrs Jean Christie
Mrs Jenny Norton
Mrs Joan Giulian
Mrs Joyce Eastham
Mrs Lilian Blackwell
Mrs Margaret Carlberry
Mrs Margaret J. Lindsay
Mrs Margaret Semple
Mrs P M Burns
Dying with dignity consultation

Dr John Mooney
Dr Kris Jozajtis
Dr Michael Reiss
Dr Peter M Barham
Dr Richard Anderson
Dr Stewart Moffat
Drs. Rob and Rose Proudlle
Duncan Robertson
Edwin Still
Eileen Amelia
Eileen Higgins
Elizabeth Bolton
Emma Martin
Eric Miller
Eur Ing Hugh Wynne
Eva Fox–Gal
Fiona Cameron
Frances Alexander
G. Kirkland
Geoffrey Hilliard
George Hart
George Herriott
George Paxton
Gerald and Brenda Masters
Geraldine Strickland
Gill and John Clemens
Gordon D. H. Bruce
Graham Winyard
Guido Papp
Heather Shipley
Hilary French
Hugh Rolfe
Iain Luke MP
Ian Cameron
Ian Leslie
Ian McDonald
Ian Mursell
Iris and Joe Lawley
Ms Kathleen Neville
Ms Maureen Laverty
Ms Nicky Day
Neil McTaggart
Nicola Ward
Ninian Hewitt
Noel Simon
Norma Kinnison
Norman Crabtree
P. A. S. Blake
Pam Mills
Pat Carpenter
Pat Smyth
Patricia and Dale Keller
Paul Culatto
Pauline Lock
Pearl Marshall
Peter Allen
Peter and June Fox
Peter Mapp
Philip Carr
Philip Mallett
Prof Peter H Millard MD PhD FRCP
R W Sutherland
R. J Davidson
Rev Jim Patterson
Reverand John Jewsbury
Richard and Jacky Sales
Richard Whitehouse
Robert Green
Robert John Rickard
Ella Dingwall Rickard
Robin Farquhar–Oliver
Robin Orr
Roger Partridge
Roger Styring
Ronald Hartwell
Ronald Shelton
Ronnie Mackay
Dying with dignity consultation

Isobel McLachlan  Rora Pagliieri
J Michael Sharman  Rosemarie Phillips
J Tait  Ruth Speeding–Jones
Jackie Gray  Sallie Brooker
Jacqui Wardrope  Sally O’Neill
Jamie Allan BSc, CPA EPA  Sally–Jayne Marshall
Jan Bowden  Sandra Hudson
Jane Carbert  Sandy Burnham
Jane Goodman  Sandy Darlington
Jane Munro  Sarah Oliver
Jane O’Gorman  Scott Macfarlane
Jane Roberts  Shana Goldman
Janet Tildesley  Sharron Brook
Jasmine Jenkins  Sheila Clifford
Jean and Stanley Denney  Sheila Colbeck
Jean Hewitt  Sheila Smith
Jean Robertson–Molloy  Sheppy Shephard
Jeanette MacRae  Shirley Cannon
Jennifer R Campbell  Shirley Prahms
Jill and Brian Garner  Simon Robinson
Jill Edwards  Simon Shearer
Jim Tuttle  Stella Welsh
Jo Draycott  Stephanie Osborne
Joan Cararach  Stewart Davie
Joan Gibson  Sue Thompson
Joan Lovell  Susan Clough
Joe R Coates  Sylvia Lewin
John Amps  Sylvie Sutton
John Dodson  Tam McGuinness
John Hostler  Teri Warren
John Hull  Terry Dunne
John J. E. McEroy  Tish Henderson–Pritchard
John Lennox  Tom Burnham
John McArthur  Toni Pearson
John Nisbet  Tony and Pamela Brooman
John Preston  Tony Remedios
John W Bleloch  Valerie Coast
John Widger  Valerie Moss
Jon Steel  Veronica and Jonathan Hunt
Jonathan Maytham  Victor Tuck
Jose Baddeley  Walter Coultrup
Josephine Cecil  Wayne Williams
Dying with dignity consultation

Joyce Rogers
Jude Cleary
Judith McMullan
Julia G. Coxon MA
Julia Lane and Family
Julie Richardson
Kate Barnes
Kate Walker
Kathleen Brody

Willem van der Eyken
William R Primrose
William Riley