Health and Sport Committee

Stage 1 Report on Assisted Suicide (Scotland) Bill
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Health and Sport Committee

To consider and report on health policy, the NHS in Scotland, sport and other matters falling within the responsibility of the Cabinet Secretary for Health, Wellbeing and Sport, and measures against child poverty.

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Note: The membership of the Committee changed during the period covered by this report, as follows:
Mike MacKenzie and Dennis Robertson replaced Aileen McLeod and Gil Paterson on 21 November 2014
Introduction

1. The Assisted Suicide (Scotland) Bill (“the Bill”) was introduced into the Scottish Parliament on 13 November 2013 by Margo MacDonald MSP.

2. Sadly, Margo MacDonald passed away on 4 April 2014. On the Bill’s introduction, Patrick Harvie MSP had, under Rule 9.2A of the Parliament’s Standing Orders, been designated as an additional “member in charge” of the Bill. Such a member can exercise any right conferred on the “member in charge” by Standing Orders. Patrick Harvie MSP took over responsibility for the Bill after Margo MacDonald’s death.

3. The Health and Sport Committee was designated as the lead committee by the Parliament on a motion of the Parliamentary Bureau on 27 November 2013. The lead committee is required, under Rule 9.6.1 of the Parliament’s Standing Orders, to report to the Parliament on the general principles of the Bill.

4. Following the Bill’s introduction, the Committee issued a call for evidence which ran from 13 March 2014 to 6 June 2014. The Committee received 886 submissions during this period with 16 further submissions after the closing date.

5. The Committee took evidence on the Bill at its meetings on 13, 20 and 27 January and 3 and 17 February 2015.

6. The Justice Committee was assigned as secondary Committee for Stage 1 consideration of the Bill. It published its report to the Health and Sport Committee on 8 January 2015.

7. The Bill was also considered by the Delegated Powers and Law Reform Committee and the Finance Committee.

8. The Committee would like to thank everyone who provided written and oral evidence as part of its consideration of the general principles of the Bill. The Committee recognises that the proposed legislation touches lives in a deeply personal way and thanks those individuals in particular who provided personal accounts of their experience of caring for seriously ill loved ones or being present in the lead up to their death.

Background to the Bill

9. The Bill is the second attempt by the late Margo MacDonald MSP to introduce a form of assisted dying in Scotland.

10. Her previous End of Life Assistance (Scotland) Bill was considered by the Scottish Parliament in Session 3. This Bill was scrutinised by an ad-hoc Committee, the End of Life Assistance (Scotland) Bill Committee.
11. The End of Life Assistance (Scotland) Bill was defeated after the Stage 1 debate by 85 votes to 16, with 2 abstentions.

Main provisions

12. The Policy Memorandum states that the Bill’s policy objective is to—

> “Provide a means for certain people who are approaching the end of their lives to seek assistance to end their lives at a time of their own choosing, and to provide protection in law for those providing that assistance.”

13. The Bill seeks to legalise assisted suicide for certain individuals. To be eligible to receive assistance to commit suicide under the Bill, an individual would require to:

- Be diagnosed with an illness or progressive condition that was terminal or life-shortening;
- Have come to the conclusion that his or her quality of life was unacceptable and that there was no prospect of any improvement;
- Be aged 16 or over;
- Be registered with a Scottish medical practice; and
- Have the legal capacity to make such a decision.

14. The Bill proposes a three-stage approval process consisting of a preliminary declaration, a first request and a second request. The first and second requests would need to be endorsed by two medical practitioners.

15. The Bill does not specify what means of death would be available to an eligible individual, but the accompanying documents to the Bill envisage what would constitute ‘physician assisted suicide’, whereby a doctor would provide a prescription for a drug that would end the person’s life painlessly. The Bill envisages the cause of death being the result of the individual’s own act and no-one else’s.

16. The Bill also provides for the creation of the role of Licensed Facilitator to offer comfort and reassurance and such practical assistance as the person reasonably requests, and to have responsibility for reporting the death to the police.

17. The Bill would exclude any civil and criminal liability for a person involved in providing assistance. It also contains a ‘savings clause’ to protect anyone who, acting in good faith and not carelessly, makes a statement or acts in a way that is inconsistent with the Bill.
Committee’s evidence and analysis

Assisted suicide and the existing law

“Lack of clarity”

18. In England and Wales, anyone who “aids, abets, counsels or procures” the suicide (or attempted suicide) of another person commits a statutory offence under section 2 of the Suicide Act 1961; the approach of the relevant authorities to prosecuting this statutory offence is set out in a published policy. By contrast, there is no statutory offence of assisting suicide in Scotland. Here, assisted suicide is governed by the common law relating to homicide, and no offence-specific guidance equivalent to the Crown Prosecution Service (CPS) policy for England and Wales has been published by the Crown Office and Procurator Fiscal Service (COPFS) in Scotland.

19. The Committee received evidence which criticised the lack of certainty in the existing law relating to assisted suicide in Scotland. The Justice Committee Report noted that Professor Alan Miller of the Scottish Human Rights Commission perceived a problem with—

“the lack of foreseeability on, and of accessibility to knowledge of, whether any informal action that individuals and families might take to assist suicide would lead to criminal sanctions being taken against them”.

20. Professor Miller told the Justice Committee that “families and legal professionals need much more certainty”. Professor James Chalmers stated in his written submission: “I do not believe that the legal position can be clarified other than by legislation.”

21. Supporters of the Bill cited lack of clarity in the existing law of Scotland as one of the arguments in favour of legislating. Patrick Harvie MSP, Member in Charge of the Bill, stated that there was currently “a great lack of clarity about what …might be prosecuted and under what circumstances” and asked witnesses—

“Is the position that we are in [at present] not the most open and ill-defined legislative framework that we could possibly have…?”

22. Thus, lack of clarity in the existing law has been presented as evidence of the ‘need’ for the Bill.

Assisted suicide under the existing law of homicide

23. Whether any act of assisting the suicide of another person would result in a criminal charge and a criminal process appears to depend upon two factors:
(1) whether the act of assistance ‘causes’ the death of the other person (in the legal sense); and

(2) if it does, whether prosecution is considered, by the prosecuting authorities, to be in the public interest.

24. The answer to (2) seems clear: prosecutorial authorities in Scotland have, over time, consistently expressed the view that it will almost always be in the public interest to prosecute someone who has caused the death of another. The Lord Advocate stated, in his written submission to the Committee, that—

“there is a high public interest in prosecuting all aspects of homicide where there is sufficient, credible and reliable evidence. If the Crown considers there to be sufficient evidence that a person has caused the death of another it is difficult to conceive a situation where it would not be in the public interest to raise a prosecution but each case would be considered on its own facts and circumstances.”

25. This echoes the view expressed by the Solicitor General, in evidence to End of Life (Assistance) Bill Committee in 2010, that—

“The more serious the offence—the crime—the more likely it is that, on current law, the public interest is that we should prosecute … I would not say that a prosecution would be mandatory or would occur in all cases, but there is more than a fairly strong possibility that, applying the law, the public interest would lie in a prosecution.”

26. It also seems clear from the evidence the Committee received that the charge would only be one of murder where evidence of a “wicked intent to kill” was present; in all other cases (including, presumably, all cases where there was evidence that the motive was compassionate) any charge would be likely to be culpable homicide.

27. Thus, any uncertainty would appear to centre on the issue of causation, and the question of whether a particular step, taken to assist a suicide, would be regarded as “causing” death (factor (1) above). If it is so regarded, then according to the evidence that the Committee has received, it appears likely that a charge of culpable homicide would be brought.

Categories of assistance

28. The Committee received evidence on how various types of assistance would be regarded under the current law of homicide from two academic experts in criminal law: Pamela R Ferguson, Professor of Scots Law at the University of Dundee, and James Chalmers, Regius Professor of Law at the University of Glasgow. Both submissions addressed the question of causation in terms of a useful typology of assistance identified by Professor Ferguson.
29. Professor Ferguson’s original typology distinguishes the following types of assistance:

(1) positive, direct acts, immediately connected with the subsequent death
(2) the provision of the means of committing suicide
(3) the provision of information and advice
(4) an omission to act: failure by one person to prevent another person from committing (or attempting to commit) suicide.

30. Professor Chalmers proposed adding another category:

(5) assisting with travel abroad, or arrangements for travel abroad, to commit suicide

31. Professor Ferguson defines category (1) as covering scenarios where “there is no need for an action on the part of [the deceased]”; in other words, as referring to euthanasia (where the final act is performed by the survivor and not the deceased) rather than assisted suicide (where the final act is performed by the deceased). Depending on whether “wicked intent to kill” is present, such behaviour could constitute either murder or culpable homicide under the existing Scots law of homicide. The Bill explicitly intends that euthanasia should remain unlawful; as such, it does not seek to alter the legal status of category (1) activity as defined by Professor Ferguson.

32. The Bill would, providing its procedure was complied with, legalise certain kinds of assistance in category (2). Although as witnesses have pointed out, the Bill does not specify a single means of suicide, the Committee assumes that what the Bill would allow, in practice, would be the prescription, supply, delivery, and preparation of lethal drugs to be used in an act of suicide.

33. With regard to category (3) — provision of information and advice — Professor Chalmers considers it “very unlikely that such actions could [currently] result in criminal liability.” He quotes a leading Scots authority on criminal law in support of the view that even encouragement to commit suicide is not currently unlawful: “Where A merely encourages B to commit suicide there can be little doubt that A is not the cause of death.” If this is an accurate statement of the current position, it seems likely that the legality of category (3) behaviour would not be affected by the Bill.

34. Likewise, the Bill does not address activity in categories (4) or (5).

35. The Assisted Suicide (Scotland) Bill would not appear to alter the legal status of activity in any category other than category (2), therefore; it explicitly provides that category (1) activity should remain unlawful, and it does not seek to alter the legal status of behaviour that falls into categories (3), (4) and (5). Moreover, it would only render category (2) activity lawful if such activity complied with the procedure set out in the Bill.
Analysis of the existing law

36. While the Bill would, as Professor Chalmers points out, “provide a clear route which persons wishing to commit assisted suicide would be able to follow”, it would do so by carving out an exception in the existing common law, with the common law continuing to provide the wider legal context, as well as any sanctions for conduct which caused death but did not comply with the procedure set out in the Bill.

37. The Committee appreciates that there is no case law in Scotland relating specifically to assisted suicide, and that this could make it difficult to predict how the technical legal issue of causation would be determined in that context. As the Lord Advocate noted in his written submission, however—

“There is a considerable amount of case law in Scotland dealing with the issue of causation [generally], which would require to be carefully considered in light of the circumstances of each case.”

38. To the extent that the approach in Scotland is to treat assisted suicide not as a distinct crime, but as part of the law of homicide, any desire for an “offence-specific” understanding of causation in the context of assisted suicide, or indeed for “offence-specific” guidelines relating to the prosecution of assisted suicide, would appear to be misplaced; the specific offence is not assisted suicide in Scotland, after all, but culpable homicide, or murder.

39. On behalf of COPFS, Stephen McGowan told the Committee that homicide cases are “very fact sensitive”. Under the current Prosecution Code, prosecutors are encouraged to have regard to a wide range of factors when determining the potential criminality of conduct, including the motive for the behaviour.

40. The Committee has some concern that in setting out a process for assisted suicide, the Bill has insufficient regard for the factual circumstances that pertain in individual cases of assisted suicide. The Bill is silent about motive, for example, notwithstanding that the motivation of the assister is one of the factors that has been identified as relevant in deciding whether to prosecute cases of assisted suicide in England and Wales; and notwithstanding that motive currently makes the difference between murder and culpable homicide in Scotland (via the presence or absence of “wicked intent to kill”). This Bill does not require any particular motive on the part of the licensed facilitator; whether this is because it simply assumes that all facilitators will be motivated by compassion is unclear.

41. Whereas the present common law context seems to necessitate an approach to prosecution which is wholly responsive to the particular factual circumstances of individual cases, the proposed approach in the Bill seems to do the opposite, subsuming the spectrum of possible factual circumstances within a single, formal procedure, and potentially creating a disincentive for police and prosecutors to look behind this procedure.
42. The Committee notes that in contrast to the criticisms that existing law is deficient because it lacks clarity, another view of the existing law is that it embodies a useful flexibility, combining firm deterrence with scope for compassion. Peter Saunders of Care Not Killing told the Committee—

“The [current] law is working because the penalties that it holds in reserve provide a very powerful disincentive to exploitation and abuse and make people think twice. At the same time, it gives discretion to prosecutors and to judges to temper justice with mercy in hard cases [...] On one hand, it has a stern face to deter abuse; on the other hand, it has a kind heart to deal compassionately with difficult cases.”

Conclusions

43. Criticism of the existing law’s lack of clarity centres on the question of causation, and of which types of actions are likely to be regarded by prosecutors and courts as “causing” the death of another person.

44. Most of the criticism seems to stem from uncertainty regarding whether providing someone else with the means of suicide will be regarded as “causing” death, where the deceased person has voluntarily committed the final act by herself.

45. The Committee understands that conduct of the type described by Professor Ferguson as category (2) assistance (“provision of the means of committing suicide”) could attract a charge of culpable homicide under the existing common law, even if the deceased person has ingested the lethal drug voluntarily, depending on the circumstances and on whether prosecution is deemed to be in the public interest.

46. The Committee acknowledges that since causation is a technical legal concept, it is inevitable that there will be a degree of uncertainty about how it will apply in particular cases. This is by no means a unique feature of the law relating to assisted suicide.

47. Lack of predictability may be heightened in the context of assisted suicide by a lack of directly-relevant case law; where an area of law is particularly “fact sensitive”, however, even prior case law will not necessarily allow for reliable prediction of the outcome in an instant case.

48. Likewise, the discretion that prosecutorial authorities have to decide whether prosecution would be in the public interest is by no means unique to assisted suicide; prosecutorial authorities rightly possess such discretion in relation to the prosecution of all crimes.

49. The policy goal of permitting assisted suicide is a separate issue from “lack of clarity”. The observation that the current law contains uncertainty does not
necessarily weigh in favour of enacting the present Bill, since the Bill’s purpose is not the neutral purpose of ‘clarifying’ the law, but the separate purpose of making assisted suicide clearly lawful if the requirements in the Bill are fulfilled.

50. The Committee notes that this Bill has limited potential to clarify the law in relation to assisted suicide. The Bill, if it became law, would sit within the structure of the present law; it would operate to exclude liability only if the requirements set out in the Bill were met. The Bill does not provide for a general clarification of the law on assisted suicide. Assisted suicides which took place outside the scope of the Bill would still be dealt with under the common law. The common law (and any uncertainty therein) would remain the fall-back position.

51. Neither the Bill, nor any prosecutorial guidelines relating specifically to assisted suicide, could render the law completely clear and unambiguous, since: (i) the Bill would not eliminate reliance on the common law, and (ii) whatever legislation was enacted and/or guidelines issued, prosecutorial authorities would still retain the ultimate discretion to decide that a prosecution would not be in the public interest.

52. The Committee considers that, although the uncertainty in the current law is perceived by some to be a disadvantage in the current position, this must be weighed against two advantages of the existing law: its ability to provide a strong deterrent as a safeguard against wrongdoing, and its ability to be sensitive to the facts of individual cases. The Committee believes that the law should continue to provide strong deterrence, and to be responsive to the facts of particular cases.

Compassion and the need to respond to the suffering of others

Assisted suicide as a compassionate response to suffering

53. Supporters of the Bill emphasise that, when intolerable suffering or distress exists, it is compassionate to provide relief from that suffering, and cruel to refuse it. This argument featured in a number of the individual written submissions to the Committee, as well as in the submission received from the Scottish Unitarian Association, and those from the campaigning groups My Life, My Death, My Choice; Doctors for Assisted Suicide; and Friends at the End.

54. Giving oral evidence to the Committee on behalf of My Life, My Death, My Choice, Dr Bob Scott said: “In our view, underlying the bill are three concepts…freedom of choice—autonomy—for the individual, but also compassion and tolerance.”

55. In their oral evidence to the Committee, both Sheila Duffy, of Friends at the End, and Jennifer Buchan, of the Humanist Society Scotland, spoke of the need to respond to suffering with compassion. Sheila Duffy said: “to those who are at the
end of their life and who are suffering intolerably, we must offer the possibility of assisted suicide.”

Jennifer Buchan said—

“I am a nurse who has worked in hospitals and in the community. I have worked with people who have dreaded the time when living would become unbearable for them. I have sat on the beds and held the hands of people who have asked me to help them to go every day for weeks, and I have not been able to do that: I have had just to sit by their beds.”

Other ways of responding compassionately to suffering

Attitudes to illness/disability and support for living

56. Opponents of the Bill reject the idea that the best way to respond compassionately to individuals suffering severe physical pain and/or psychological/emotional distress is to assist them in committing suicide. Some written submissions argue that the Bill requires doctors, and ultimately the state, to agree with individuals that their quality of life is so poor that their suicides may be facilitated, rather than actively prevented (see also below under the heading “Suicide prevention strategy”).

57. For some opponents, therefore, notwithstanding the compassionate motives of the Bill’s promoters and supporters, the very identification of eligibility criteria risks engendering negative social attitudes about those who would be eligible under the Bill.

58. Giving evidence on behalf of Inclusion Scotland, Dr Sally Witcher stated that in her view, negative attitudes toward illness, old age and disability already exist and are a factor in creating demand for assisted suicide—

“Much of the support for bills such as this one is driven by a profound fear of becoming disabled, ageing and becoming ill. Rather than say that we should make it easier for people with that profound fear to end their lives or let them feel confident that they could do so should that terrible thing happen…we need to challenge those negative attitudes and have public policy that ensures that, when people are old, ill or disabled, they get the best quality of life possible, and that the right sort of support is available to enable full and independent living as equal citizens for as long as possible.”

59. In Dr Witcher’s view—

“What determines quality of life is not necessarily someone’s condition; it is to do with the services that they receive and whether the services and support that they get accord them dignity or choice and control…Maybe if someone does not have dignity, choice and control in the way that they live, dignity, choice and control about the way that they die becomes rather more important to them… it [should be] about getting dignity, choice
and control in the way that people live their lives and supporting people to have the best quality of life.”  

60. She concluded—

“I would reject the idea that dignity becomes an impossibility at any point with palliative care, the right support and so on.”

Prioritising palliative care

61. The importance of prioritising wide access to good-quality palliative care was also emphasised by a number of the Bill’s opponents, many of whom contrasted this type of response to suffering favourably with the response proposed in the Bill. Dr Peter Saunders of Care Not Killing noted—

“palliative care involves not just the relief of physical symptoms, but physical, social and spiritual care—it is total-person care—and we know that, when people have their physical, social and spiritual needs properly met, requests are rare even in countries that allow euthanasia or assisted suicide. That must put the onus on us to ensure not just that the very best care is available but that it is made accessible and affordable to people.”

62. Richard Meade, giving evidence on behalf of Marie Curie Cancer Care, emphasised the need to focus on widening access to palliative care—

“We would like the focus to be on ensuring that the kind of palliative care that Dr Hutchison just described is available to everybody who might benefit from it. At present in Scotland, it certainly is not available to everybody and, when people get it, it often comes much too close to the end, when they could have benefited from it for far longer.”

63. Some written submissions likewise emphasised that good quality palliative care is care that responds to the “physical…emotional and spiritual needs of people coming to the end of their lives.”

64. Doctors for Assisted Suicide state, in their written submission, that—

“There are limits to the effectiveness of palliative care. With even the best care, some patients suffer intolerable pain, loss of dignity and severe misery. Making assisted suicide available as another option of care would improve end of life care and ensure that the end of life is more tolerable for more people.”

65. Supporters of the Bill see no reason why palliative care and assisted suicide cannot co-exist as complementary options. Sheila Duffy of Friends at the End claimed that—
“In the Netherlands [where euthanasia and assisted suicide are permitted], for example, the palliative care system is much better than what we have here. I do not view the issue as either/or. The two things go hand in hand, and palliative care and hospice care will improve if the bill is passed.”

66. Opponents see a tension between the two, however, and regard the legalisation of assisted suicide as being likely to undermine the priority accorded to palliative care. Dr Francis Dunn of the Royal College of Physicians Glasgow reported a disquiet in the medical profession that—

“if assisted suicide was an option, it could affect other options, such as further development of the palliative care movement. If [assisted suicide] had come in 20 years ago, it would have diminished the impetus for the palliative care movement. There are still many further developments that could be made in palliative care, particularly for non-malignant conditions. If assisted suicide were an option on the table, it would not be possible to explore the other options in the same way. That is a real issue.”

67. Dr David Jeffrey, a specialist in palliative care, described an ‘ethos’ of accompanying patients in their suffering as fundamental to palliative care; he explained this as “The promise that palliative care provides—of ‘I will not abandon you; I will be with you’” and expressed concern that this ethos might be undermined by the existence of assisted suicide as an option.

68. Summing up the perceived tension between palliative care provision and the legalisation of assisted suicide, the written submission from Strathcarron Hospice argued that “palliative care cannot flourish alongside euthanasia”, and that “rather than enacting legislation, we need the political will to make the care of [the] dying a priority for our society.”

69. Both supporters and opponents of the Bill agreed that responding to the suffering and distress of others was a moral imperative. Supporters of the Bill maintained that such a moral response could include assisting suicide. Sheila Duffy stated: “Supporting assisted suicide is the right thing to do.” Dr Bob Scott of My Life, My Death, My Choice echoed this in his own oral evidence, describing legalisation of assisted suicide as “the right thing to do.” Opponents warn, however, that instead of crossing a moral and legal “Rubicon” by legalising assisted suicide, society should be focusing on other ways to respond compassionately to human suffering, by prioritising palliative care and (where appropriate) supporting people to live rather than assisting them to die.

Conclusions

70. The Committee acknowledges that a desire to be compassionate toward those who are suffering is a key factor motivating the Bill, and its supporters. The Committee also acknowledges the concerns of opponents of the Bill who argue that this laudable aim carries risks that they consider to be too high: the risks
associated with crossing a legal and moral “Rubicon”. The Committee notes that opponents believe there are other ways of showing solidarity and compassion with those suffering distress, short of helping them to commit suicide.

71. The Committee notes that some witnesses consider that the introduction of lawful assisted suicide would be liable to undermine the provision of palliative care. Nevertheless, the Committee is agreed that, regardless of whether the Bill progresses beyond Stage 1, there is a need for a thorough investigation and scrutiny of current provision and future plans for palliative care in Scotland.

Respect for autonomy

72. Respect for autonomy is a key underpinning principle of the Bill. The Policy Memorandum to the Bill refers to “people’s rights to control the timing and manner of their own deaths”, and to individuals “retain[ing] control of their lives”. Witnesses have described respect for autonomy as the “aim” and “guiding principle” of the Bill, and its “driving force”.

73. The Committee appreciates that the principle of respect for autonomy has considerable ethical, legal, and cultural importance. The law already recognises that adults with capacity ought, in most cases, to be allowed to make their own life choices, and that this is particularly true where the most intimate and important life decisions are concerned. In the context of the present Bill, it has been argued that in a matter so intimate and important as the manner and timing of a person’s death, the autonomous wishes of the person concerned should be given paramount importance, and the person’s own values should be the ones that govern the decision-making process. The Member in Charge described the Bill as—

“the continuation of a decades-long change in healthcare and medical practice that has involved a considerable move away from a slightly top-down approach—as some witnesses acknowledged—to one that is much more focused on patient empowerment, patient decision making and the principle that each of us has the right to determine major choices about our own lives.”

Autonomy as qualified

74. The Member in Charge acknowledged that “autonomy is not and never has been regarded as an absolute principle”. The Committee notes that personal autonomy is always limited, in several ways.

75. First, the exercise of autonomy is always limited. The right of each individual to self-determine is limited by the equal right of self-determination of all other individuals; as Robert Preston of Living and Dying Well observed, “The autonomy of the individual has to be balanced against the rights of other people.”
76. Likewise, Dr Peter Saunders of Care Not Killing observed that “we are all thankful that we live in a democratic society that respects autonomy, but we also recognise that there are limits to autonomy and that we are not entitled to exercise freedoms that undermine or endanger the reasonable freedoms of others.”61

77. Other witnesses noted that individual autonomy must also be balanced against public safety considerations,62 and the “needs and interests of the many”.63 In the medical context, Dr Francis Dunn of the Royal College of Physicians and Surgeons of Glasgow observed that—

“[Clinicians] respect the autonomy of the patient, but there is the greater picture of what impact the decision will have on the greater body of patients…[whether] tragic individual cases with which everybody sympathises…should lead to a major change for the whole population is a question that doctors find very difficult.”64

78. In the context of the Bill, it has been argued that, when deciding whether to respect the autonomy of someone who wishes to die by providing the assistance s/he would need, it is necessary to consider how changing the law to accommodate this might affect the autonomy of others. One argument the Committee heard was that changing the law might lead to a change in culture whereby other vulnerable patients end up feeling themselves under a ‘duty to be dead’,65 or end up with fewer choices because the introduction of assisted dying has led to a decreased emphasis on, for example, palliative care, or support for people with disabilities.

79. Even in the healthcare context, where autonomy is the ‘dominant’ value, it is limited; patient autonomy does not entitle people to insist on particular treatments which their doctors do not consider to be clinically-indicated, or which their health authority does not fund. As Professor David Jones of Anscombe Bioethics Centre pointed out in his evidence—

“although we have a right to refuse interventions, we do not have a right to demand interventions irrespective of what the medical establishment or society thinks or what a particular doctor thinks would be beneficial in a specific instance.”66

80. Despite giving patients with capacity an absolute right to refuse treatment, therefore, autonomy does not ground any right to insist on treatment — positive choice is not as free as negative choice.

81. Second, it seems clear that autonomy is only one among several values that require to be considered in this context. For example, although “human dignity” is not emphasised by those promoting/supporting this Bill, and although some witnesses have expressed scepticism about the usefulness of discussing dignity in the context of assisted suicide, it is undoubtedly the case that human dignity is “an established and orthodox legal concept”67 which is acknowledged, for example, to
underpin human rights systems. The sanctity of life principle is also part of our law, and features in the reasoning of judges in medical law and criminal law cases.\textsuperscript{68}

82. Third, autonomy is valued and respected, not as an abstract phenomenon, but as part of the process of valuing and respecting persons. As one witness observed, “it is because each of us believes that we have value and worth that we respect the autonomy of others.”\textsuperscript{69} We may choose, therefore, to place the need to respect the intrinsic value of the person ahead of the need to respect particular manifestations of the person’s autonomy.

**Autonomy as relational/reciprocal**

83. The principle of autonomy is increasingly understood as a ‘relational’ and/or ‘reciprocal’ principle.\textsuperscript{70} On this understanding, individuals seeking to exercise their autonomy ought to do so in a way that takes account of their responsibilities to the wider community, and to other individuals (particularly vulnerable individuals). Dr Stephen Hutchison of Highland Hospice told the Committee—

> “We function as a relational and interdependent society... Therefore, we need to look at choice with responsibility. To me, that puts a completely different emphasis on the issue, as it is then not [only] about what the individual chooses and demands. That is part of the equation, but it has to be balanced with careful scrutiny of the implications for the rest of society and, in particular, for the vast numbers of frail, vulnerable and frightened people whom [clinicians] look after.”\textsuperscript{71}

84. Relatedly, several witnesses rejected the idea that the decision to commit assisted suicide is mainly a private decision, and a matter of individual autonomy. As the Reverend Sally Foster Fulton of the Church of Scotland explained—

> “it comes down to the way in which we look at death...[if we regard it] as something very personal and private—as 'my death'...[then] 'my right to decide' seems completely and utterly sensible. It is when we dig a bit deeper that we see the community aspect of all our lives and how my life and my death and what I choose may have unforeseen implications for others. I think that that is one of the main reasons for the Church of Scotland's decision to oppose this legislation.”\textsuperscript{72}

85. Dr Salah Beltagui of the Muslim Council of Scotland pointed out that, paradoxically, although the decision to commit assisted suicide will inevitably involve a range of other people, the decision seems to be approached in the Bill as one taken by the individual in isolation, since no provision is made in the Bill for any consultation to take place in advance of the preliminary declaration or during the process—

> “no advice is to be given to the person before he decides that he wants to be assisted. We ask for help with any transaction or process in our life—we
ask a legal expert, a financial expert, even a car mechanic for example—but the decision about ending one’s life is put in the hands of the person. They decide that they want to end their life and everything follows on from there.”

Autonomy and end-of-life decision-making more generally

86. The Scottish Partnership for Palliative Care neither supports nor opposes the Bill. Giving evidence on the organisation’s behalf, Mark Hazelwood observed: “End-of-life issues are much bigger than the particular, narrow issue [of assisted suicide].” Mr Hazelwood pointed out that—

“There are [already] many ways within existing legal frameworks in which people in Scotland can exercise choice and control and increase the chances of arriving at the sort of care at the end of life and at death that they might choose.”

87. Mr Hazelwood cited the examples of making advance directives, writing wills, funeral planning, and creating powers of attorney. In many cases, people at the end of life are also able to exercise autonomy and choice in relation to treatment options, including exercising the right to refuse treatment (discussed below at paragraphs 94-101).

88. Thus, the unavailability of assisted suicide as an option does not reflect a general lack of autonomy, according to Mr Hazelwood; rather, the problem is “a cultural reluctance to talk about end-of-life issues and…[resulting] low levels of public knowledge and awareness…We need to create a much more open dialogue about death, dying and bereavement.”

Conclusions

89. The Committee acknowledges that the principle of respect for autonomy is a qualified principle which is usually limited by the rights of others, by public safety considerations, and by the need to consider other principles and values.

90. If assisted suicide were to be permitted, robust safeguards would be required to protect the rights of others (for example, so that people with illnesses and disabilities would continue to feel valued and be provided with the support they need to live full lives, and so that healthcare professionals would not come under any pressure to be involved in the assisted suicide process). Safeguards to address public safety considerations would also be necessary. The issue of safeguards is considered at various points throughout the remainder of this Report.

91. Even if the rights of others and the safety of the public can be guaranteed, the principle of autonomy does not require that assisted suicide be permitted by law,
since there may be other legal and ethical principles and values weighing in favour of maintaining the current prohibition

92. Therefore, the Committee is not persuaded that the principle of respect for autonomy on its own requires the legalisation of assisted suicide.

Assisted suicide and other end-of-life practices in healthcare

93. Some supporters of the Bill argued for the legalisation of assisted suicide on the basis that practices currently take place in the healthcare context which result in patients’ deaths.

Withdrawal/refusal of life-sustaining treatment

94. There was some discussion in the oral evidence sessions regarding whether it is morally and/or legally inconsistent to prohibit assisted suicide when the law allows patients with capacity to refuse life-sustaining treatment, and allows doctors to withdraw futile treatment from patients with incapacity, in the knowledge that these steps will result in death. Given that the law permits passive steps resulting in death, the question is whether there is any logical basis for disallowing active steps. Is not the refusal of life-sustaining treatment by a patient tantamount to suicide?

95. A number of witnesses on both sides of the debate rejected the idea that there is no relevant difference between the two types of situation. Dr David Jeffrey noted a “huge moral and clinical difference [between assisted suicide and treatment refusal]”. The Reverend Sally Foster-Fulton described the difference between them as “profound and distinct”, and the Member in Charge of the Bill acknowledged a “category distinction.”

96. Some witnesses explained the nature of the difference as being the difference between “accepting” death and positively seeking it. Robert Preston, for example, observed that “when a patient refuses [life-sustaining] treatment, that is not the same as saying ‘I wish to die.’” Likewise, the Reverend Sally Foster-Fulton spoke of “a proactive move to end life, rather than to take advantage of…what is left of that life.”

97. The nub of these observations is that the patient can refuse further treatment while having no positive wish to die; indeed, such a refusal can be congruent with a wish to enjoy the remainder of life as much as possible. On the other hand, assisted suicide seemed to the Reverend Dr Harriet Harris to represent “death [being] chosen for its own sake.”

98. Evidence from Baroness Finlay of Llandaff, a palliative care specialist, reveals another factor which distinguishes assisted suicide from treatment refusal, namely that when patients refuse life-sustaining treatment “their disease process carries on” and they die of their underlying condition. By contrast, the process the Bill
would establish would deliberately foreshorten life “before the disease process
progresses.”

99. Professor David Jones pointed out yet another distinction: “we respect refusals of
treatment” he said “because there is a right of non-interference, which is to do with
our limits on how we bump into each other.” In the context of medical law and
ethics, when a patient withdraws consent for treatment, the legal justification for
providing that treatment (consent) is no longer present, and the treatment must
immediately be withdrawn. Thus, one relevant legal (and ethical) distinction
between the passive and active examples is the requirement that where a patient
has capacity, interventions must be consensual. The law respects patients’
refusals of life-sustaining treatment not because it endorses patients’ judgments
about the quality of their lives, and not because it regards them as having the right
to end their lives, but simply because it does not permit the treatment of
competent patients without their consent. It is not the logical corollary of this rule
that the law must also permit assisted suicide.

100. A final point of contrast is highlighted in Professor Sheila McLean’s evidence:
namely, that when treatment is refused, or when futile treatment is withdrawn,
medical professionals do not feel “implicated” (morally responsible) for those
things; by contrast, “when assisted suicide is legalised, medical professionals feel
themselves to be directly implicated in it.”

Conclusion

101. The Committee notes that there are, therefore, a number of relevant legal
and ethical differences between assisted suicide on the one hand and the
refusal of life-sustaining treatment on the other. The fact that the law
accepts the latter need have no bearing on the attitude it adopts toward the
former.

The doctrine of double effect

102. The Policy Memorandum to the Bill states—

“While it has long been accepted that the levels of medication necessary to
manage pain effectively during the final stages of a terminal illness can
have the effect of shortening life, some doctors have been prepared to go
further, prescribing or administering deliberately higher doses than needed
for pain-management in order to bring the patient’s suffering to an earlier
end.”

103. Some of the written submissions received by the Committee made similar claims
about doctors deliberately assisting or hastening death by administering higher
doses of painkillers than are actually required to ease pain. On the basis of these
claims it was argued that the Bill would in fact serve to clarify and regulate what is
currently practised by healthcare professionals in a covert, unregulated, and “risky” manner.

104. The current legal position is as follows. Under the existing law, it is established that a doctor may lawfully administer a dose of painkilling drugs to a patient with the purpose of easing the patient’s pain, even where the doctor knows that the dose is likely (or certain) to have the incidental effect of hastening the patient’s death.\(^89\) This is known in law as the “doctrine of double effect”.\(^90\) It is fundamental to the operation of the doctrine that the doctor’s primary purpose in administering the dose must be to relieve the patient’s pain, and that the hastening of death is an incidental, even if clearly foreseen, side-effect.

105. In their textbook on *Law and Medical Ethics*, JK Mason and GT Laurie explain that the doctrine can apply to consensual treatment (where the patient is conscious and consents) as well as to non-voluntary treatment (where the patient cannot consent).\(^91\)

106. The doctrine means that intolerable physical suffering can already be relieved within the parameters of the current law. To the extent that doctors are currently acting in the way covered by the doctrine, they are acting in a legally and ethically sound manner.

107. The doctrine of double effect does not, however, permit a doctor to administer a lethal dose of a painkilling drug to a patient whose suffering is purely non-physical (emotional, psychological, or existential). Any doctor who did so would currently be committing homicide. Insofar as the Bill does not appear to envisage non-physical suffering as establishing eligibility for assisted suicide, such behaviour would remain unlawful were the Bill to be enacted.

108. Importantly, the doctrine of double effect applies to the conduct of the medical practitioner, not the layperson (whether friend, relative, ‘facilitator’ or anyone else). The doctrine exists within the context of the beneficial therapeutic relationship between doctor and patient, as part of patient care; it makes sense as a legal doctrine only within that context, so that it cannot be extended or transplanted outside of it.

109. Where it operates, the doctrine of double effect covers actions which would otherwise be described as *euthanasia*, rather than assisted suicide, since the final act is performed by a healthcare practitioner and not by the patient.

**Conclusion**

110. The Committee notes that, as with the withdrawal and refusal of life-sustaining treatment, double effect makes sense as a treatment decision within the context of the therapeutic relationship between healthcare professional and patient. Moreover, treatment refusals and double effect are both distinct from assisted suicide in a number of practical ways. The logic of these practices does not
require that assisted suicide be permitted for the sake of legal or moral consistency, therefore; assisted suicide cannot be justified ‘by extension’, but would require an independent justification.

Experience from other jurisdictions

111. Experience of legalised assisted suicide and euthanasia in other jurisdictions has been cited both by supporters and opponents of the Bill. Most of the detailed discussion of other jurisdictions has referred to Belgium, the Netherlands, and the US state of Oregon.\(^{92}\)

Background information

Belgium

112. In Belgium, only euthanasia is lawful. It is permitted under the Euthanasia Act 2002. Cases of euthanasia have increased from 24 reported cases in 2002 to 19,807 reported cases in 2013, although euthanasia is likely to be under-reported given (i) that there is no penalty for failing to report (recent research estimated that the reporting rate in 2007 was likely to be around 52.8%), and (ii) that professional guidance from the Belgian medical profession’s governing body advises members not to enter euthanasia as a cause of death on death certificates. In 2012 and 2013, the large majority of cases of euthanasia in Belgium involved patients suffering from cancer.

113. Three criteria must be satisfied before euthanasia can lawfully be provided:

- the patient must be competent
- the request must be voluntary and consistent, and
- the patient must be “in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated resulting from a serious and incurable disorder caused by an illness or accident”.

114. Euthanasia was initially restricted to patients over the age of 18 and minors over 15 who had been ‘legally emancipated’. However, recently the law was extended to all ages, although children would require the approval of their parents and counselling by doctors and a psychologist/psychiatrist.

The Netherlands

115. In the Netherlands, euthanasia and assisted suicide are both permitted under the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001.

116. The procedure can only be performed by a physician, who must:
• be satisfied that the patient has made a voluntary and carefully considered request;
• be satisfied that the patient’s suffering is unbearable and that there is no prospect of improvement;
• have informed the patient of his or her situation and further prognosis;
• have come to the conclusion, together with the patient, that there is no other reasonable alternative;
• consult at least one other, independent physician, who must see the patient and give a written opinion on whether the due care criteria set out above have been fulfilled;
• have exercised due medical care and attention in terminating the patient’s life or assisting in his or her suicide.

117. The law can be used by those over 18 and patients between the ages of 12 and 18 who are ‘capable of making a reasonable appraisal’ of their own interests. Where a patient is aged between 16 and 18, a parent or guardian must be consulted, but need not consent. The consent of the parent or guardian is necessary where the patient is aged between 12 and 16.

118. Each death under the Act must be reported, first to the local state pathologist and thereafter to a regional Review Committee which has the power to investigate should it think it necessary to do so.

119. Total deaths from euthanasia and assisted suicide in the Netherlands increased from 2331 in 2008 to 4188 in 2012. This increase may be at least partly accounted for by improved reporting as the system bedded in. The vast majority of reported deaths (94.7% in 2012) are by euthanasia, rather than assisted suicide. As in Belgium, the majority of those who make use of the law are patients suffering from cancer (78% in 2012).

120. In Oregon, physician-assisted suicide is lawful under the Death With Dignity Act 1994, but euthanasia remains unlawful. The only process permitted by the Act is the provision of a lethal prescription by a physician which must then be self-administered by the patient.

121. The only criteria in Oregon are that the patient must be aged over 18 and suffering from “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgement, produce death within six months”. There is no additional requirement regarding intolerability, unbearable suffering, or the like.
122. Physicians must report each prescription written under the Act, as well as each death resulting from ingestion of the prescribed substance. There is no penalty for not reporting a prescription or a death.

123. In 1998 there were 16 deaths under the Act; this rose to 71 deaths in 2013. As in the Netherlands and Belgium, cancer is the most common diagnosis among those who use the law; 64.8% of those who died in 2013 were suffering from cancer.

Evidence to the Committee

124. Supporters and opponents of the Bill disagreed regarding what could be read into the experience of assisted suicide/euthanasia in other jurisdictions.

125. Supporters generally interpreted the evidence from elsewhere as indicating that assisted suicide can be legalised in a safe, controlled manner and with no adverse effects.

126. Regarding fears about incremental extension of such laws once enacted, Dr Peter Saunders of Care Not Killing warned that—

“Once you create an exception and a right for some people, you immediately set yourself up for new hard cases to come along that challenge the boundaries under equality legislation. As we have seen in the Netherlands and Belgium, there is a gradual weakening and broadening of the categories of people.”

127. On the other hand, Sheila Duffy of Friends at the End observed that “The [Oregon] law has been in place for 17 years and it has not been amended, broadened or changed in any way.”

128. Dr Saunders argued that although the law itself might not have been formally extended in Oregon, nevertheless “people go up to the new law and then beyond it. … Even in Oregon, we see the scope going far beyond what is in the law.”

129. Professor Graeme Laurie of Edinburgh University’s Mason Institute pointed out that deaths from assisted suicide in Oregon still account for only a “tiny” percentage of total deaths there. Nevertheless, Dr Saunders argued that three kinds of “drift” are inevitable once assisted suicide becomes lawful—

“In the US states of Oregon and Washington, in Belgium and in the Netherlands, we see three key things. The first is an annual increment in the number of cases. For voluntary euthanasia cases in the Netherlands, it has been 10 to 20 per cent a year since 2006. The second thing is a widening of the scope. It starts with the terminally ill, and then it is the chronically ill. It starts with adults, and now in Belgium it is children. It starts with the mentally competent and it then shifts to the mentally incompetent—those with dementia. The third thing, and probably the most worrying of all, is that as time goes on we see a change in the public
conscience and the medical conscience. That does not worry some people, but it worries me a lot that the public conscience changes so that people come to accept situations that, 10 or 20 years ago, they would have found intolerable.”

130. Witnesses also disagreed about what the evidence shows regarding how vulnerable people are likely to be affected by legislation. Dr Bob Scott of My Life, My Death, My Choice told the Committee—

“there is no evidence in Oregon that theoretically vulnerable groups in society—the very old, the less well-off and the disabled—are more likely to resort to assisted dying than would be suggested by their proportion in society.”

131. By contrast, Gordon Macdonald of CARE for Scotland observed that—

“Linda Ganzini…conducted a study that showed that 26 per cent of people who requested assisted suicide in Oregon were depressed. There are concerns in Oregon about not just people who are depressed but the lack of safeguards and reporting mechanisms; there are quite a lot of concerns about the way that the system operates in Oregon.”

132. Finally, there was also disagreement about the usefulness of drawing on experience from other jurisdictions. Some witnesses regarded the US state of Oregon as a reasonable comparator for the Scottish context because of the roughly comparable population size in the two jurisdictions, and because Oregon has chosen to legalise assisted suicide but not euthanasia (which is what the current Scottish Bill seeks to do). Others have argued that Oregon is not an appropriate comparator because the eligibility criteria in the Scottish Bill go “very far beyond terminal illness” which is the criterion for eligibility in Oregon.

Conclusion

133. Ultimately, while experience in other jurisdictions can be informative and can provide a limited basis for reflection, the Committee acknowledges that other jurisdictions differ from one another, and from the proposals in the Scottish Bill, in terms of eligibility requirements, reporting requirements, what form of assistance they permit, and the cultural context within which they operate (or would operate).

134. For all of these reasons, the Committee acknowledges that experience in other jurisdictions “cannot be read across automatically into the Scottish context” as evidence either for or against the Bill.
Key terms not defined in the Bill

“Assisted suicide” and “euthanasia”

135. Several witnesses criticised the Bill for failing to define key terms. Among the key terms not defined in the Bill are “assisted suicide” itself, and “euthanasia”. Insofar as the purpose of the Bill is to permit assisted suicide while explicitly providing that euthanasia remains unlawful, the failure to define either term is surprising.

136. In oral evidence, the Member in Charge clarified—

“...The basic principle is that the final act—that which causes the individual's death—must be taken by the individual themselves, rather than by another person.”

As one witness pointed out, however, this simply means that disagreement will focus on “the fine nuances of what counts as the final act.”

137. The Committee heard from several witnesses that in practice, the distinction between assisted suicide and euthanasia could be a “fine line”. Stephen McGowan from COPFS, for example, advised that “the line between assisting someone and taking the act out of that person's hands is a fine one.”

138. A related point is that the Bill does not specify a means of suicide; it seems to be widely assumed (including by representatives of pharmacists' professional bodies) that the Bill envisages the ingestion of a lethal dose of drugs. However the language of the Bill refers to “any drug or other substance or means”. This further complicates attempts to establish what the line between assisted suicide and euthanasia would look like in practice.

Conclusion

139. The Committee notes the concern expressed by some witnesses that the Bill does not distinguish adequately between “assisted suicide” and “euthanasia”. The Committee appreciates that, for some, this gives rise to concern that because it does not define either term, the Bill does not specify precisely which actions it intends to shield from liability. It can be argued that this is further obscured by the lack of clarity in the Bill regarding the means of suicide.

“Terminal” and “life-shortening” illness and “unacceptable” quality of life

140. The terms “terminal” and “life-shortening” appear, on the face of the Bill, to be absolutely central in delineating the range of persons who would be eligible to receive assistance in ending their lives were the Bill to pass into law. Neither of these terms is defined, however, and “terminal” entails nothing specific in terms of remaining life expectancy.
141. Regarding “terminal”, Doctors for Assisted Suicide said, in their written statement, “we…welcome the fact that no time limits are laid down by the Bill. Doctors are often inaccurate in predicting how long someone has to live. In addition, distress that may last a longer time requires at least as much attention as short-lived distress.”106

142. However, David Stephenson QC for the Faculty of Advocates observed—

“it therefore seems to follow [from the lack of definition] that any illness that shortens a person’s expectancy of life is life shortening. The Faculty of Advocates’ submission pointed out that many everyday conditions are likely to be life shortening. For example, type 2 diabetes can shorten life; it might do so by only a relatively short time, but it could nonetheless be argued that it is a life-shortening condition.”107

143. Mr Stephenson QC also observed, however, that a terminal or life shortening condition is not the only eligibility requirement; the Bill also requires that the person seeking assistance must regard his or her own quality of life as “unacceptable”108 and must see “no prospect of any improvement”. 109 Mr Stephenson QC regarded this as “quite a high hurdle” to overcome in order to be eligible;110 in his view, no-one would be likely to conclude that his or her quality of life was unacceptable and without prospect of improvement on the basis that s/he had type 2 diabetes.111

144. The Bill seems not to preclude this, however, and it is possible to imagine people suffering from other life-shortening conditions, such as various forms of addiction, feeling that their quality of life was currently unacceptable and seeing no prospect of improvement.

145. Theoretically, a “condition” need not necessarily be a medical condition, and there was brief discussion in one of the evidence sessions of the fact that certain non-medical conditions, such as poverty, reduce life expectancy.112 While it is clearly not the intention of the Bill that people should be eligible for assisted suicide on the basis of non-medical life circumstances, it is far from clear that the Bill as currently drafted excludes that possibility.

146. It is also unclear under what circumstances a doctor would be justified in overruling a person’s subjective assessment of the quality of his or her own life, and the lack of prospect for improvement, as “inconsistent with the facts” under section 9(2)(c) or section 11(2)(c). One witness remarked that “I do not see how a doctor could turn anyone down under the Bill.”113

Conclusion

147. The Committee considers that the Bill’s failure to define these key terms leaves far too many people potentially eligible to receive assistance.
“Best endeavours” and “comfort and reassurance”

148. Precisely what the Bill would permit, in terms of assistance, is further obscured by the failure to define terms used to describe the function of the licensed facilitator: “best endeavours” (section 19) and “comfort and reassurance” (section 19(b)). A number of witnesses have commented that these phrases are vague; Baroness Finlay wondered whether “comfort and reassurance” might cover “reassurance that they are doing the right thing [by committing suicide]”. Again, although the idea of facilitators actually encouraging suicide may seem distasteful, there appears to be nothing in the Bill to prevent it, and it is not clear that “reassurance” could not mean this. Professor Chalmers regards it as unlikely that ‘encouragement’ of suicide is currently unlawful, so the existing law cannot be regarded as providing a safety net in this regard.

Use of term ‘best endeavours’ in relation to the issuing of directions and guidance for licensed facilitators

149. The Delegated Powers and Law Reform Committee (DPLRC) in its report drew the use of the term “best endeavours” to the attention of the Health and Sport Committee.

150. The DPLRC considered the use of this term within the context of Section 23 of the Bill which provides for the Scottish Ministers to issue directions and guidance for facilitators and licensing authorities. Section 23(2) provides that a licensing authority must use its “best endeavours” to ensure that these directions are complied with by the facilitators to whom it has granted licences.

151. The DPLRC report explains that the nature of the obligation imposed on licensing authorities should be clear and transparent. The report states—

“The level of compliance implied by the phrase “best endeavours” is fundamentally uncertain. The Bill gives no definition of the phrase, nor any indication as to what it may mean in the context of the provision; neither does the Bill set out any process by which compliance may be measured or achieved.”

152. The DPLRC considered, therefore, that the use of the phrase “best endeavours” in section 23(2) rendered the obligation on licensing authorities effectively meaningless.

153. Following the publication of the DPLRC report the Member in Charge of the Bill wrote to the DPLRC. His letter explained that whilst he was of the view that the use of the term ‘best endeavours’ in the context of 23(2) was sufficiently clear, he indicated his willingness to take the DPLRC concerns into account. He suggested that it may be possible to adjust section 23(2) in order to require licensing authorities to make facilitators aware of any directions issued, and also to require facilitators to comply with any such directions.
154. The Convener of the DPLRC wrote to the Health and Sport Committee welcoming the Member in Charge of the Bill’s suggestion of an adjustment to section 23(2). However the DPLRC stated that it would welcome a further step in the process, requiring the licensed facilitators to acknowledge that they are aware of the directions.

Conclusion

155. The Committee supports the suggestion made by the DPLRC that section 23(2) ought to require licensed facilitators to acknowledge that they are aware of Ministerial directions.

“Savings for certain mistakes and things done in good faith” (section 24)

156. Section 24 provides protection from liability for those who make incorrect statements, or do anything else that is inconsistent with the Bill’s provisions, so long as they are “acting in good faith and in intended pursuance [of the Bill]”, and have not been careless. The rationale behind section 24 is a sense that it would be undesirable if people who made minor or technical errors in complying with the procedure set out in the Bill were to find themselves outside the Bill’s parameters and without its protection, and at risk of being charged with a common law crime.

157. The term “careless” is not defined in the Bill; nor is the phrase “acting in good faith and in intended pursuance [of the Bill]”.

158. On behalf of COPFS, Stephen McGowan expressed the view that, while the intention in including section 24 may have been merely to protect from prosecution those who have committed technical errors (such as errors in completing paperwork), the provision has the potential also to make prosecution difficult in other circumstances. In his evidence before the Justice Committee, Mr McGowan expressed particular concern about the phrase “acting in good faith and intended pursuance…”, which he said may mean “that [evidence of] any step towards trying to comply with the Act would cause difficulty in a prosecution if we were to bring one.”

159. Following the recommendation in paragraph 16 of the Justice Committee’s report, the Health and Sport Committee explored the potential for the wide drafting of the savings clause to create “difficulties with enforcement”.

160. Witnesses expressed similar concerns to the Health and Sport Committee that the ‘savings clause’ in section 24 of the Bill is drafted too broadly; in particular, insofar as the Bill seeks to provide safeguards for vulnerable people, the Committee heard concerns that these could be undermined (“blunted”, in the words of one witness) by the effect of the savings clause.

161. The Member in Charge of the Bill indicated that he would be open to a rewording of the savings clause which replaced the word “careless” with “negligent” or
“reckless”. Such a revision would not address the aforementioned problem raised by Mr McGowan, however.

162. The Member in Charge was asked specifically whether, given that, in practice, the distinction between assisted suicide and euthanasia can be a “fine line”, someone who made a good faith and non-careless error about where that line was to be drawn could be “saved” from liability by section 24. The Member responded that, in his view, since the Bill provides for the legalisation of assisted suicide only and makes clear that euthanasia remains unlawful, it would be clear that such an error could not be consistent with acting “in pursuance of this Act”. 122

163. However, the effect of the wording of section 24 seems to be that, as long as an assister believed that his or her actions amounted to assistance, and not to euthanasia, and as long as that belief was a good faith belief and not the result of carelessness, s/he would benefit from the protection in the savings clause. That the assister’s actions had in fact crossed the line into euthanasia, and been inconsistent with the Bill’s intentions, would not exclude the protection in section 24, providing that the intention of the assister had been to provide assistance and not euthanasia (i.e. “to act in pursuance of the Bill”). Given that the Bill does not define either concept, and given the acknowledgment by experts that what counts as the ‘final act’ could be a subject of discussion and disagreement, such an error seems possible, and section 24 would appear to exclude liability providing that the error was made in good faith and in the belief that the line between assistance and euthanasia had not been crossed.

164. David Stephenson QC remarked in evidence that—

“if we criticise the existing system for uncertainty, we should do our best to remove uncertainty when creating a legislative regime.”123

Conclusion

165. It seems clear that in numerous respects, some of which go to the heart of the Bill’s purpose, the language of the Bill would introduce much uncertainty. In the context of a statute that makes an exception to the law of homicide and permits one person to assist in the death of another, such significant uncertainty must be unacceptable and would require to be addressed should Parliament approve the Bill at Stage 1.

Mental capacity

No mandatory psychiatric assessment

166. There is no provision in the Bill for routine mandatory psychiatric assessment of every patient who requests an assisted suicide. The Royal College of Psychiatrists (RCP) indicated in its written submission that it would not expect its members to be involved in the routine psychiatric assessment of patients requesting suicide.124
In oral evidence, drawing a comparison with treatment withdrawal decisions, Dr Stephen Potts of the RCP said—

“At the moment, when a patient says, “I want to stop dialysis” and their doctor agrees, we do not have a concern that that decision is open to legal challenge. We do not require that doctor always to refer every such patient to a psychiatrist. Probably half of the patients in my hospital who are in that condition do not get referred to my department and I accept that. I do not see any reason clinically—and with an amateur’s understanding of the law—why it would be necessary to make such referral automatic.”

167. Although Dr Potts’ view was that there was no need for “automatic recourse to psychiatric assessment” he considered nevertheless that “doctors must have it available…at every stage” and that the RCP accepted that psychiatrists would have a role in the process to that extent.

168. In contrast with this view, a range of other stakeholders, including the Royal College of Physicians of Edinburgh, indicated that routine psychiatric assessment was, in their view, a necessary safeguard.

169. Coral Riddell of the Law Society of Scotland noted that “different degrees of capacity are required for different decisions” and that there was a need to ensure that the person making a decision had capacity which was commensurate with the magnitude of the decision being taken. There is a connection between this point, and the question (discussed below) of whether, if assisted suicide were legalised, decisions about it would be ‘ordinary’ treatment decisions.

The eligibility of persons with mental disorders/ with a history of mental disorder

170. David Stephenson QC pointed out on behalf of the Faculty of Advocates that the first stage of the test for capacity set out in section 12 of the Bill requires the person making the assessment to ascertain that the individual being assessed “is not suffering from any mental disorder…which might affect the making of the request”. Mr Stephenson expressed the Faculty’s concern that this “involves a medical decision that looks like a psychiatric decision,” and that it may not be appropriate for such an assessment to be made other than by a specialist psychiatrist.

171. Depending on how widely the phrase “…not suffering from any mental disorder…which might affect the making of the request” is interpreted, it could operate to render all persons with mental disorders ineligible for assistance.

172. David Stephenson QC gave the example of a person with cancer who also has a previously-diagnosed mental disorder. Might a request from someone in such a situation be turned down on the grounds that the previously-diagnosed disorder “may” be affecting the person’s judgment, even if the person’s request is ostensibly based on their sense that the suffering unacceptably as a result of the cancer? In other words, might practitioners exercise such extreme caution in
applying the test for capacity under section 12 as to create an effective ‘blanket ban’ on assistance for anyone with any history of mental disorder?  

173. Dr Stephen Potts of the RCP expressed concern that psychiatrists may find themselves forcing treatment upon suicidal psychiatric patients who claimed to be suffering “unacceptably” and wished to die, on the one hand, while simultaneously authorising assisted suicide for patients suffering “unacceptably” as a result of physical conditions on the other. He observed—

“My psychiatric colleagues will have the everyday experience of seeing people who have depressive illnesses saying things like, ‘My life is intolerable. I can’t go on. I would be better off dead. Please let me die.’ I am talking about people who do not have qualifying physical conditions and the everyday job of psychiatrists is to treat such people, sometimes against their will, under mental health legislation, in the full expectation that they will recover from the episode as they have recovered from all their previous episodes. If psychiatrists are asked in those circumstances to enforce treatment on people who have depressive illnesses, and to essentially authorise assisted suicide in other cases when the patient has a physical disorder, that would be an acute dilemma and I do not know how the profession would resolve it.”

174. Dr Potts considered that any blanket ban on permitting persons with mental illness from accessing assisted suicide “would be unsustainable and inappropriate”.

Assessing capacity in people who are terminally-ill, and in young people

175. Regarding the difficulty of assessing capacity in patients near the end of life, Dr David Jeffrey stated—

“I believe that safeguards in this area are totally illusory. We are kidding ourselves, because of the complexity of dealing and working with patients at this stage of life... We know—there is hard evidence to show—that we are not good at detecting depression in this particularly difficult group. Linda Ganzini has shown elegantly in her studies that depression in patients whom she had identified as having depression and who had assisted suicide was not picked up by their clinical carers. These are people with treatable depression. If we cannot diagnose depression, all safeguards disappear; there is no safeguard there.”

176. The written submission from the British Psychological Society agreed that the assessment of capacity in people with terminal illness is complex. In particular, according to the Society—

“Psychologists, who work in ‘end of life care,’ understand that cognitive, emotional and mental health functioning may suffer significantly or be impaired as a result of treatment and/or medication.”
177. By contrast—

“Co-morbid depression is often missed by non-psychologists and may be amenable to intervention and change negating the desire to proceed with assisted suicide.”¹³⁸

178. As such—

“the fluctuating nature of some conditions, such as depression or suicidal ideation, particularly in palliative care requires specialist skills above and beyond that of medical practitioners and is not addressed [in the Bill].”¹³⁹

179. In light of this—

“The Society recommends that assessment of capacity would be better viewed as a process rather than a ‘one off’ meeting where consideration of assisted suicide is taking place.”¹⁴⁰

180. Dr Pat Carragher, representing the Children’s Hospice Association Scotland (CHAS), noted that the issue of capacity may also need to be approached with greater caution where young people are concerned—

“An increasing amount of work is available to show that young people, even up to the age of 25, do not fully understand the absolute significance of death and do not understand that death would be final for them.”¹⁴¹

Conclusions

181. The Committee concludes that the difficulty in assessing capacity in terminally ill people and in people under the age of 25 seems to weigh in favour of a requirement that requests for assisted suicide by persons falling into one or more of these categories be subject to expert psychiatric assessment.

182. The Committee notes that the Bill as currently drafted may exclude anyone with a history of mental disorder. Assuming that the Bill may intend to make assisted suicide available in some circumstances to persons with such a history, the Committee considers that any request for assisted suicide from someone with a history of mental disorder ought always to be assessed by an expert psychiatrist, since the assessment of capacity in such cases could be a complex process requiring specialist skill.

183. Where a person requesting assisted suicide falls into one or more of these specific categories, then, the Committee takes the view that routine mandatory psychiatric assessment of the request for assisted suicide may be necessary. As noted already, however, there may be overarching reasons, connected with the momentous nature of the decision to commit suicide, for requiring routine
psychiatric assessment in all cases where a request for assisted suicide is made.

184. In general, the Committee considers that if the decision to pursue assisted suicide is not an ordinary treatment decision, it may be appropriate to adopt more stringent safeguards in assessing individuals’ capacity to make such decisions.

Coercion

185. A number of witnesses raised concerns about the potential for coercion of vulnerable people if the Bill were to become law. Baroness Finlay described the risk of coercion as a “public safety issue” and noted the absence of “any safeguard in the bill or any way of detecting coercion.”

186. Professor David Jones pointed out that people are vulnerable, not just to coercion, but to “influence”, which is wider. He noted that individuals may be influenced in the direction of suicide by a range of factors including their own subjective sense of being a burden; this is a concern which was also raised by a number of witnesses in different evidence sessions.

187. Professor Chalmers’ evidence suggests that it is not currently an offence in Scotland to influence or encourage someone to commit suicide, unless the influence or encouragement is sufficient to be regarded, in law, as having ‘caused’ the person’s death.

188. Professor Laurie indicated that he would support the creation in the Bill of a specific offence which would apply in “cases where manifest undue influence has been established” and which would carry a specific penalty.

189. Some witnesses acknowledged the difficulty of establishing coercion in practice, however. Dr Peter Bennie of the British Medical Association noted that “there is no way to guarantee that someone has not been coerced.” Addressing the possibility that doctors may be expected to discover cases of coercion, he commented that “it is certainly hard for me to conceive of a way in which a doctor could be certain that there was no coercion. That is part of what, under the Bill, doctors would be asked to arrive at a decision on, and I do not know how they could be certain about that.”

190. Professor Sheila McLean suggested, by way of solution, that requests for assisted suicide could be authorised by a specially appointed “judicial or quasi-judicial body” equivalent to the Court of Protection in England. Following the decision of the House of Lords in the case of Airedale NHS Trust v Bland [1993] A.C. 789, whenever it is proposed that life-sustaining treatment be withdrawn from a patient who lacks capacity, an application must be made to the Court of Protection for authority to proceed.
191. Professor McLean proposed that a similar system could be introduced in Scotland in relation to assisted suicide, so that if any concern existed about the circumstances under which a request was being made, including concerns about capacity or coercion, a court could scrutinise the request. Professor McLean observed—

“The courts have plenty of experience of deciding about whether somebody has been coerced into making a decision. That might provide the ultimate safeguard that people seem to be looking for. The quasi-judicial or judicial body [would be] a mechanism not to judge quality of life, as the person has done that [for] themselves, but to decide whether a person is making an informed, free and uncoerced decision.”

192. Likewise, Baroness Finlay wondered whether it might be beneficial to adopt a system whereby “a person intent on having an assisted suicide can apply to a court, which can take evidence on the person’s medical condition and its predicted pathway”. She noted—

“In the England and Wales system, the Family Division of the High Court already takes decisions on, for example, treatment cessation…and difficult Jehovah’s Witness blood transfusion decisions.”

Conclusions

193. The Committee suggests that, should Parliament approve the Bill at Stage 1, the Member in Charge may wish to consider some of the suggestions from witnesses regarding measures aimed at minimising the risk of coercion.

194. However, the Committee notes the observation by the BMA that there is no way to guarantee the absence of coercion in the context of assisted suicide.

The role of healthcare professionals

Assisted suicide as ‘treatment’

195. Members of the Committee sought views from witnesses regarding whether assisted suicide was being regarded in the Bill as a ‘treatment option’, or indeed whether it could be properly regarded as such.

196. Dr Bob Scott, of My Life, My Death, My Choice, stated in oral evidence that “It is an exceptional provision that is being proposed [in the Bill], not a routine part of medical care.”

197. One witness who engaged directly with the question of whether assisted suicide can be part of a treatment process was Baroness Finlay, who was very clear in her view that “deliberately ending life is not treatment” and that “we should take the whole thing out of the area of medicine.” Elsewhere, referring to the lethal
drugs which might be used to bring about suicide under the Bill, she remarked: “they are not medication or treatment – they are nothing to do with treatment.”

198. Arguably, if assessing and endorsing requests for assisted suicide is not properly regarded as part of a treatment process, the Bill’s reliance on the involvement of healthcare professionals at various stages is inappropriate, and effectively expands the boundaries of medical practice to include involvement in the assisted suicide process (albeit that the Bill does not envisage healthcare professionals as providing the direct ‘assistance’ itself).

199. On the other hand, if assisted suicide is to be regarded as part of a treatment process, this may create an expectation that practitioners will be willing to involve themselves in the parts of the process they are envisaged as performing. Arguably, the ability to resist such an expectation would be seriously limited in the absence of robust protection for conscience (discussed below at paragraphs 210-228).

Informing patients of their treatment options

200. Although the Bill appears to envisage assisted suicide as something that would be raised by the patient in the first instance, when the preliminary declaration is made, opponents pointed out that in fact the Bill does not require that it be the patient who makes the first mention of assisted suicide. Indeed, Dr Peter Saunders of Care Not Killing pointed out that “once we legalise assisted suicide, we make assisted suicide a ‘treatment’ option for a range of conditions, which means that a general practitioner or other doctor is obliged to present it as a treatment option.”

201. Dr Peter Bennie, of the British Medical Association, considered the question “if the Bill became law, would that in effect mean that a discussion about assisted suicide could be seen as a necessary part of a discussion of therapeutic options?” He concluded: “It seems to me that would be a significant possibility.”

202. Likewise, Professor David Jones stated: “I do not think that there is anything in the Bill that would stop a doctor from suggesting assisted suicide as a reasonable option among a patient’s treatment options. There is nothing stopping a doctor saying, ‘I think in your situation I might consider assisted suicide.’ If it is a normal end-of-life decision, it would not be coercive to suggest that among the range of decisions.”

203. In its written submission, the campaign group My Life, My Death, My Choice expressed the view that it was desirable that doctors be able to discuss assisted suicide with their patients—

“The current law that makes assisting suicide a crime means that neither the patient nor the health professional can easily broach the subject without risk of criminal action or suspicion of professional wrongdoing. Is there any
other medical situation where a doctor is not allowed, or obliged, to honestly answer a question from a patient?"159

204. In the group’s view, therefore, the Bill would improve upon the current situation by enabling open discussion of suicide between doctors and their patients.

205. Dr Saunders pointed out, however, that “as a treatment option, [assisted suicide] gets costed. When we put the cost of chemotherapy or radiotherapy at tens of thousands of pounds and the cost of palliative care or hospice care at £3000 or £4000 a week against the cost of a glassful of barbiturates – five quid – it is inevitable that there will be pressure to take the cheapest treatment option.”160

Conclusions

206. The Committee notes that, if assessing and endorsing requests for assisted suicide is regarded as “medical treatment”, this may mean that assisted suicide can be presented to patients by professionals as a “treatment option”, which in turn may influence patients' attitudes and even their decisions.

207. The Committee also notes, however, that both supporters and opponents of the Bill acknowledge that the involvement of healthcare professionals in assisted suicide, even if it were legal, would not amount to “medical treatment”.

208. This should mean that assisted suicide cannot be presented to patients as a treatment option. There seems to be nothing in the Bill at present which would preclude this; however professional bodies would be expected to issue guidance to their members if the Bill were passed into law, and such guidance may address this issue.

209. If assisted suicide is not “treatment”, however, this raises the separate question of whether the level of involvement which the Bill envisages for healthcare practitioners is appropriate, albeit that the Bill does not seek to impose any positive duty on practitioners to be involved.

Protection for conscience

The need for protection and the issue of legislative competence

210. The analysis of written submissions to the Health and Sport Committee noted that “virtually all respondents commenting on opting out and conscientious objection believe that doctors, pharmacists, solicitors and others involved in the process must be able to 'opt out'.”161 The need to provide for conscience-based exemption appears to be common ground between supporters and opponents of the Bill: My Life, My Death, My Choice, for example, commented in their written submission to the Committee that “it is important that no doctor should be forced to take part”.162
211. The Committee appreciates that ostensibly, the Bill imposes no positive duty on anyone to participate in the assisted suicide process. Nevertheless, the Committee is cognisant that if assisted suicide becomes lawful, and becomes an accepted part of healthcare practice, an expectation may well develop that general practitioners, pharmacists, and in some cases psychiatrists, palliative care physicians, other hospital-based clinicians, nurses and possibly other healthcare professionals will be willing to be involved.

212. Dr Peter Saunders made a comparison with the Abortion Act 1967, and pointed out that “the treatment that is prescribed becomes part of the full range of treatments that are required under the specialty concerned, and pressure will inevitably be placed on doctors, nurses and pharmacists.” The Abortion Act theoretically imposes no positive obligation on practitioners to participate in abortion, yet there is nowadays an undeniable expectation that practitioners (GPs, and hospital-based nurses and doctors in certain specialisms) will be involved, unless they claim exemption under section 4(1) of that Act.

213. In relation to assisted suicide, Dr Stephen Potts of the Royal College of Psychiatrists (RCP) noted in his written submission that: “if participation [comes to be] considered part of NHS duties, there is a strong case for an opt-out provision.”

214. Aileen Bryson of the Royal Pharmaceutical Society referred to a conscience provision as “an absolute must” and expressed her organisation’s preference that protection for conscience be statutory, rather than the subject of professional guidance.

215. Although the need to protect conscience is a matter of principle, and would be important regardless of the spread of views within the professions potentially affected by the Bill, protection for conscience is all the more urgent in the context of legislation to permit assisted suicide because of the evidence that many members of healthcare professions would not wish to participate in the process were the Bill to become law.

216. Discussing the need for a conscience provision, Dr Francis Dunn reported that “Within my organisation [the Royal College of Physicians and Surgeons of Glasgow], the majority view is very much that the proposals [in the Bill] impinge on the trust relationship between doctor and patient.”

217. Dr Peter Bennie for the BMA stated that he was “confident” that a majority of BMA members opposed the Bill.

218. Dr Stephen Potts reported that the RCP had polled its membership in 2010 in connection with the End of Life Assistance (Scotland) Bill (which envisaged a greater role for psychiatrists than the current Bill does) and found that two thirds of respondents would be unwilling to participate. Dr Potts expressed the view that the level of opposition to the present Bill may not be as high as two-thirds, given the absence from the present Bill of any requirement for routine psychiatric assessment, and that polling would need to be carried out to be sure; however he
believed that the number of his colleagues opposed to the present Bill “might well be a substantial proportion and it could be a majority”.168

219. Baroness Finlay cited statistics indicating that “only 4 per cent of licensed palliative medicine doctors are prepared to have anything to do with assisted suicide and 96 per cent are not.”169

220. It is foreseeable that some, if not many, of those who would wish to avail themselves of the provisions of the Bill might be long-term in-patients in hospitals or hospices. The Committee notes that a widespread unwillingness of practitioners to participate may have the practical effect of restricting access to assisted suicide for such patients, as they will not be in a position to ‘doctor shop’ in order to find a willing practitioner.

221. The Committee understands that, because regulation of the professions is a reserved matter, it would not be competent to include a conscience provision in a Scottish bill. Neither could the provision be made for conscience rights in secondary legislation of the Scottish Parliament.

222. However, the Committee understands that, should this Bill to pass into law, it would, in theory, be possible in terms of legal principle under section 104 of the Scotland Act 1998, for an order to be made by a UK Minister and laid before the UK Parliament to provide for a “conscience clause” in Scotland enabling relevant health professionals to refrain from providing assistance under the Bill on grounds of conscience. Such an order can make provisions on matters that are reserved to Westminster, in consequence of an Act of the Scottish Parliament.

223. The Committee invites the member in charge, should the Parliament approve the general principles of the Bill, to explore the extent to which this possibility might be realistic and to report on this to the Committee in advance of Stage 2.

Statutory protection versus professional guidance

224. Several witnesses have suggested that an acceptable alternative would be to allow professional bodies (such as the General Medical Council, for example) to provide for conscience-based exemptions in the guidance they issue to their members.

225. However, professional guidance is not legally-binding; this was discussed in the Court of Session in the recent case of *Doogan v Greater Glasgow Health Board* [2013] CSIH 36 in which Lady Dorrian noted, in the Inner House, that—

> “The guidance of the [Royal College of Midwives] and similar guidance from other professional bodies was relied upon by the respondents. However, such guidance, from however eminent a body, was not relevant. It was for the court to determine the meaning of the legislation.” [para. 20]
226. Not only are conscience-based opt-outs in professional guidance not legally-binding; they can also be revised or repealed without any legal process having to be followed. They do not create any legal protection, and therefore cannot be regarded as a substitute for statutory provision.

227. On behalf of the Faculty of Advocates, David Stephenson QC made the point that, if practitioners were to exercise an opt-out without explaining the conscientious basis of their unwillingness to participate, the false impression may be created in the mind of the person requesting suicide that s/he was being turned down because s/he was not eligible to be assisted under the legislation. It was suggested that in order to avoid this, practitioners declining to participate on grounds of conscience should be required to make the requester aware of the conscientious reason for declining, so that the person will know that another practitioner may be willing to facilitate the process for him or her.

Conclusions

228. The Committee notes the strong view of many stakeholders, and particularly of the Royal Colleges and other professional bodies, that meaningful protection for conscience would be essential if Parliament were to legislate to permit assisted suicide in a way that involved healthcare professionals in the process. The Committee notes the significant difference between statutory protection and provision made other than by statute, and shares the legitimate concern of the professions and others in relation to this issue.

229. The Committee understands that, were this Bill to pass into law, it would, in theory, be possible in terms of legal principle under section 104 of the Scotland Act 1998, for an order to be made by a UK Minister and laid before the UK Parliament to provide for a “conscience clause” in Scotland enabling relevant health professionals to refrain from providing assistance under the Bill on the grounds of conscientious objection. Such an order can make provisions on matters that are reserved to Westminster, in consequence of an Act of the Scottish Parliament.

230. The Committee invites the member in charge, should the Parliament approve the general principles of the Bill, to explore the extent to which this possibility might be realistic and to report on this to the Committee in advance of Stage 2.

231. Were it possible to make adequate provision for conscience in the Bill, the Committee would consider that any practitioner who declined to participate in the assisted suicide process for reasons of conscience should be required to inform the person requesting suicide that the refusal is conscience-based, so as to avoid creating the impression in the mind of the person requesting assisted suicide that s/he is not eligible for it.
The role of the licensed facilitator

Support for the role of ‘licensed facilitator’

232. The creation of the role of ‘licensed facilitator’ has been widely welcomed by supporters of the Bill. It has been described in written submissions from supporter organisations as “a welcome measure”,\(^\text{170}\) “a large step forward”\(^\text{171}\) and “one of the main merits of the Bill”.\(^\text{172}\) Supporters point to several potential advantages.

233. First, the role of facilitator places a degree of distance between medical professionals and the direct act of assistance; this may be necessary given the reported reluctance among members of the healthcare professions to be involved in facilitating assisted suicide (discussed above); in the words of Rob Jonquière of the World Federation of Right to Die Societies, it “takes away a burden from the shoulders of the treating physician”.\(^\text{173}\)

234. Second, the role of licensed facilitator is described by several supporters’ organisations as a “safeguard” for the person committing suicide. In their written submission, for example, Friends at the End suggest that the facilitator role “offers additional protection for the vulnerable”.\(^\text{174}\)

235. References to the role as a “safeguard” seem to refer to two things: first, the fact that assistance would be provided by a trained individual, thus allowing for “a safe and careful execution of the (assisted) suicide”;\(^\text{175}\) and second, the fact that the assister would have no personal connection to the person being assisted, unlike friends and family members who may feel motivated to try to interfere with the autonomous decision of the individual (either by encouraging someone to commit suicide or by attempting to dissuade them from doing so).\(^\text{176}\)

236. Third, some supporters have suggested that the role of facilitators could be augmented. The Humanist Society of Scotland propose, in their written submission, that—

> “It may be worthwhile enhancing the role of the facilitator beyond what the Bill proposes. For example, they could be given authority to check that all the necessary steps had been correctly followed and that appropriate records were kept and centrally recorded…It would be important to keep and publish a statistical account of the process. That could include a record of the numbers of individuals obtaining a prescription; the numbers who ultimately consumed the drug; the underlying diagnoses; their ages and gender. Licensed facilitators could be responsible for gathering this data and the licensing body could collate the information and publish it as an annual report.”\(^\text{177}\)

237. Friends at the End make a very similar suggestion in their written submission.\(^\text{178}\)

238. Doctors for Assisted Suicide suggest, in their submission, that “doctors might have some role to play” in the training of facilitators.\(^\text{179}\)
Lack of clarity about the role

239. As discussed above at paragraphs 148 and 149-155, some of the language used in the Bill to describe the facilitator’s function (notably the phrases “best endeavours” and “comfort and reassurance”) is ambiguous. There has been a corresponding concern from some of the witnesses that the role of the facilitator is unclear. Professor Sheila McLean expressed uncertainty regarding the purpose of the facilitator role, other than its purpose of distancing healthcare professionals from direct acts of assisting suicide.180

240. There is also lack of clarity about the precise nature of the assistance that facilitators would be permitted to provide. In their written submission, Doctors for Assisted Suicide said: “we believe that more clarity is required about what the facilitator is and is not allowed to do.”181 The present lack of clarity is partly the result of a silence in the Bill regarding the means of suicide; as noted already, the assumption is that the facilitator would assist with the collection, delivery, and preparation of lethal drugs, but the relevant language in the Bill refers to “any drug or other substance or means”. Whatever the means used, the line between assistance and euthanasia has been spoken about in evidence in terms of who performs the “final act”, but the precise degree of physical assistance that a facilitator may provide to a patient without crossing the “fine line” into euthanasia is neither self-evident nor specified in the Bill.

241. David Stephenson QC pointed out that there appears to be no requirement that the licensed facilitator be present at the time of death. “If that is correct” he continues, “it raises the question why the facilitator is described in the supporting papers as a ‘safeguard’”.182 Mr Stephenson also noted that “the facilitator is the only person who has obligations in relation to reporting the death or the attempted suicide.”183 Accordingly, if the facilitator “[was] not there and does not know what has happened”, there would appear to be “a gap in the reporting provisions”,184 since no-one else has the responsibility to report anything to anyone.

242. Professor David Jones asked, with reference to the facilitator role, “who guards the guards?” and suggested that a body with overall authority to scrutinise and police the activities of facilitators ought to be part of any new legal framework if the Bill becomes law.185

Directions and guidance for licensed facilitator

243. As discussed previously in this report the DPLRC as part of its consideration of the Bill’s delegated powers considered Section 23(1) of the Bill which would make provision for the Scottish Ministers to issue directions and guidance for facilitators and licensing authorities and Section 23(3) which would provide that a licensing authority must have regard to any guidance issued by the Scottish Ministers.

244. The DPLRC in its report to the Health and Sport Committee’s drew attention to a letter it had received from the Member in Charge, which discussed how the
powers to make directions and guidance in section 23 (1) and 23 (3) would be intended to be used by Ministers.

245. The Member in Charge’s letter explained that the powers would be intended to provide more detailed oversight, by either imposing detailed requirements on facilitators as to how they are to act in particular circumstances (in the case of directions) or by providing factual/technical guidance.

246. The DPLRC stated in its report—

“The Committee has a concern that rules as to the conduct of facilitators (in light of the anticipated significance of their role and the potential impact on individuals who may be vulnerable, and their families) should more properly be covered by regulations and should be subject to Parliamentary scrutiny.”

247. The DPLRC recommended—

“That in relation to powers in section 23(1) and 23(3), that an amendment should be brought forward to provide that any directions or guidance issued by the Scottish Ministers must, as well as being published, be laid before the Parliament on issue.”

248. The DPLRC noted in its report that the Member in Charge was supportive of such an amendment being made to the Bill.

Eligibility

249. The written submissions to the Committee reflected significant concern that the Bill would allow someone to perform the role of facilitator at 16 years of age. A number of witnesses gave oral evidence that the role would inevitably be “extremely stressful”, could cause “anguish and psychological tiredness” and that those fulfilling it would need to be “extremely psychologically robust”.

250. The analysis of the written evidence to the Committee indicates that the majority of those who regard 16 as too young would be satisfied were the minimum age at which a person could act as a licensed facilitator to be raised to 18. However, as noted above, the Children’s Hospice Association Scotland quoted evidence to the effect that, until the age of 25, people “do not fully understand the absolute significance of death”. In light of this, 18 might also be regarded as too young.

251. Witnesses also highlighted the lack of provision in the Bill for training and support for facilitators. The Committee heard that a lot of support is made available to those who work in the palliative care sector, due to the psychological and emotional demands of the work they do; Dr David Jeffery, a palliative care specialist, expressed the hope that “if the Bill is passed, such provision will be made for the facilitators as well, because it will be very stressful work.”
252. As well as questioning the value of the facilitator role generally, Professor Sheila McLean was critical of the fact that the Bill would disqualify from the role many of those from whom people would be most likely to derive support and comfort at the end of life – such as friends and family – and would restrict the role to those who are effectively “strangers” to the person.\textsuperscript{194} The rationale appears to be that the facilitator ought not to have any personal opinion about the decision to commit suicide, whereas a friend/relative might have a personal interest in either dissuading or encouraging the person. The Bill does not prevent loved ones being present at the time of death; however it does appear to prevent them from acting in the formal facilitator role.

Conclusions

253. The Committee notes a number of respects in which the role of the licensed facilitator would require to be clarified should the Parliament approve the Bill at Stage 1. In particular, clarification would be required in terms of:

- What counts as permissible “assistance”; i.e., which practical steps a facilitator may \textit{and} may \textit{not} take toward facilitating a suicide;
- The means by which an assisted suicide may be accomplished; and
- Whether the facilitator is obliged to be present at the time of the suicide.

254. The Health and Sport Committee supports the recommendation made by the Delegated Powers and Law Reform Committee that it would be preferable if there was a requirement, in relation to section 23 (1) and (3) that, as well as being published, Ministerial directions and/or guidance for facilitators must be laid before the Parliament.

255. The Committee considers that, if the facilitator would have sole responsibility for reporting the death and attesting to its procedural correctness, the Bill ought to require that facilitators make every reasonable effort to be present when the act of suicide takes place.

256. The Committee notes that any suggestion that healthcare professionals might be involved in training facilitators may heighten anxiety among professionals who are opposed to assisted suicide, particularly in light of the likelihood that protection for individual conscience cannot be addressed in the Bill.
Reporting, record-keeping and monitoring of statistics

257. The Bill provides for the recording of each stage of the process – preliminary declaration, first and second request, and any cancellation of them – in the patient’s medical records.\textsuperscript{195}

258. The Bill obliges the licensed facilitator to report any death or attempted suicide which occurs under the legislation to the police. Several key stakeholders suggested during the taking of evidence that it would be preferable for deaths or attempted suicides under the Act to be reported to the Procurator Fiscal’s office rather than to the police.\textsuperscript{196} There was general agreement with this suggestion, including from the Member in Charge.\textsuperscript{197}

259. As the Bill currently stands, the police would have a duty, upon receiving a report of a death or attempted suicide under the legislation, to investigate in the case of any reasonable suspicion that a crime had been committed. Stephen McGowan of COPFS pointed out that to enable this system to operate effectively—

"it is crucial that all the paperwork would be available in the correct place so that it could be gone through...As I understand the bill, the various declarations and pieces of paperwork would have to be noted on the medical records of the person who had expressed the will to take advantage of the legislation, but there is no central repository for all the relevant paperwork. Therefore, there is a potential issue with in-gathering all the paperwork..."\textsuperscript{198}

260. Mr McGowan explained that “[if] there was a concern that all was not as it appeared to be on the face of the paperwork, that would be investigated. It would have to be investigated.”\textsuperscript{199}

261. In addition to its lack of provision for any central gathering of paperwork relating to individual cases, the Bill also makes no provision for any central gathering or recording of all information relating to the overall operation of assisted suicide in Scotland. If information about cases of assisted suicide is recorded only in the medical records of individual patients, it is difficult to see how the practice as a whole can be monitored, scrutinised and reviewed by any central authority.

262. On behalf of the Law Society of Scotland, Professor Alison Britton suggested that it would be desirable to provide for a body “similar to the Office of the Public Guardian, where documentation could be held centrally and securely for monitoring purposes, data purposes and security, when it is collated.”\textsuperscript{200}

263. In their written submission, however, My Life, My Death, My Choice stated: “The [My Life, My Death, My Choice] campaign does not believe that any new agency or body is required to monitor operation of the Bill.”\textsuperscript{201}
Conclusions

264. The Committee considers that it would be preferable for the Bill to require that assisted suicides and attempted suicides be reported directly to the Procurator Fiscal’s office, rather than to the police.

265. The Committee considers that if information about cases of assisted suicide were recorded only in the medical records of individual patients, it would be difficult for the practice as a whole to be monitored, scrutinised and reviewed by any central authority.

266. The Committee would consider it necessary, should assisted suicide became lawful, for an independent supervisory body to be created with overall responsibility for: overseeing and scrutinising the activities of licensed facilitators; ingathering and scrutiny of paperwork; and recording, analysing and publishing data on the operation of assisted suicide in Scotland. The Committee would regard such a regulatory body as necessary in order to safeguard both the public and facilitators themselves, and would regard any form of self-regulation by facilitators as inadequate and inappropriate.

267. The same body might also be charged with monitoring the well-being of facilitators, in light of the psychological demands of the role they would be performing, and arranging counselling or other support for them as appropriate.

268. The Committee considers that providing for a central body with responsibility for maintaining accurate, up-to-date records on all cases of assisted suicide or attempted suicide under the legislation could also have other possible advantages:

- it could help to ensure that where correct procedure had been followed, mandatory reporting to law enforcement authorities could take place quickly and smoothly and without triggering an investigation;
- it could also facilitate investigation where that was deemed to be necessary;
- broadening out from individual cases, such a central repository of information about assisted suicide could also enable governmental and other appropriate organisations to monitor the practice of assisted suicide in Scotland at national level, and facilitate review of the law.

Suicide prevention strategy

269. Although there is no legal prohibition on suicide in Scotland, the Scottish Government identifies suicide as a negative social phenomenon, and strives to reduce the incidence of suicide via its Suicide Prevention Strategy 2013-2016. This mirrors the view of the World Health Organization that “[s]uicide prevention is an important priority.”

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270. The Government’s Strategy notes that “The World Health Organization has adopted a global target that suicides will be reduced by 10% by 2020. During the period of this strategy, we want to continue the downward trend in the rate of suicide in Scotland and make progress towards the WHO target.”

271. The Ministerial Foreword to the Strategy opens with the sentence: “Every suicide is a tragedy that has a far reaching impact on family, friends and the community long after a person has died.”

272. The Suicide Prevention Strategy acknowledges that: “How we talk about suicide is important. We know that talking openly about suicide in a responsible manner saves lives. We have adopted that approach through the Choose Life campaigns ‘Suicide: Don’t hide it. Talk about it’ and ‘Read Between the Lines’.”

273. The Committee acknowledges that discussion of the current Bill forms part of “how we talk about suicide”.

274. Living and Dying Well claim that the Bill “flies in the face” of suicide prevention strategies and social attitudes to suicide insofar as it “create[s] a class of people whose suicides it is appropriate to assist”. The Anscombe Bioethics Centre and the Scottish Council on Human Bioethics likewise raise the issue of suicide prevention.

275. There seem to be two main concerns about the way this Bill might interact with suicide prevention strategy. First, that enacting a Bill of this kind would undermine the aim of preventing suicide in two ways: (i) by seeming to contradict the wider suicide prevention message, or by watering it down with exceptions, and (ii) by “normalising” suicide: this argument is that when law permits a practice, this is perceived as endorsement, and as society absorbs that endorsement, the general perception of the practice changes.

276. Second, some of the written submissions express discomfort about the idea that there are any exceptions to the message that suicide is a tragedy which ought to be prevented. The concern is that, by allowing assisted suicide in some cases while seeking to prevent it in others, the law sends a message – both to society at large, and to vulnerable individuals – that not all lives are equally worthy of protection, or equally valuable or worthwhile, and that suicide is a reasonable response to the poor or low quality of some people’s lives.

Conclusions

277. The Committee acknowledges that discussion of the current Bill forms part of “how we talk about suicide”.

278. There appears to be a contradiction between a policy objective of preventing suicide, on the one hand, and on the other, legislation which would provide for some suicides to be assisted and facilitated.
279. The Committee notes that, unless assisted suicide is to be made freely available to all, any legislation permitting it must identify eligibility criteria. Where legislation to permit assisted suicide exists alongside a wider policy of suicide prevention, the eligibility criteria in the legislation serve to differentiate between circumstances in which suicide is to be regarded as a tragedy and prevented wherever possible, and circumstances in which suicide is to be regarded as a reasonable choice, to be facilitated and supported.

280. The Committee is concerned that this has the potential not only to undermine the general suicide prevention message by softening cultural perceptions of suicide at the perimeters, but also to communicate an offensive message to certain members of our community (many of whom may be particularly vulnerable) that society would regard it as ‘reasonable’, rather than tragic, if they wished to end their lives.

The 14-day window period

281. The Bill provides (in section 17(2)) for a 14-day ‘window of opportunity’ after the recording of the second request within which any act of suicide (or attempted suicide) must take place. Many witnesses expressed concern that providing for such a short ‘window of opportunity’ before being obliged to recommence the process might create a sense of momentum driving people toward an act of suicide before they felt ready. One witness even raised the possibility that the 14-day period might be experienced as ‘coercive’ because it seems to attach a sanction (i.e. having to repeat earlier stages of the process) to a failure to act within 14 days.

282. The rationale for including the 14-day limit, according to the Bill’s supporting materials, is “to minimise the chances of the person’s capacity deteriorating significantly in the interval between the second request (which is the last point when capacity is professionally assessed) and the act of suicide itself.”

283. Dr Stephen Potts of the Royal College of Psychiatrists spoke of a dual-track system in another jurisdiction whereby the time limit was 28 days in most cases, but 14 days in cases where capacity was declining quickly. This may be considered preferable to a blanket 14-day time-limit for everyone.

284. However, the Committee notes that the End of Life Assistance (Scotland) Bill Committee in 2010 took the view that a 28-day time-limit could also “encourage a person to proceed prematurely” to the act of suicide.

285. Aileen Bryson of the Royal Pharmaceutical Society informed the Committee that prescriptions would only be valid for 28 days; the implication of this is that any time-limit longer than that would mean either that the medical practitioner would have to re-issue the prescription, or that a prescription for lethal drugs had been
dispensed but not used, so that a lethal dose was at prolonged risk of falling into the ‘wrong’ hands or being used for illicit purposes.

Conclusions

286. The Committee considers that it would be unacceptable to risk the situation whereby someone committed suicide having lost capacity in the interim between the second request and the act. Thus, there appears to be a need for some sort of time restriction at least where capacity is known (or suspected) to be declining rapidly. On the other hand, it would be highly undesirable if anyone were to feel pressured, by the imminent expiry of a time limit, to commit suicide before s/he felt that the time was right to do so.

287. The Committee notes that there are alternatives to a blanket 14-day time-limit. Legislation could adopt a dual-track approach with a 28-day (or other) time-limit in most cases, but a 14-day time-limit in cases where capacity was declining quickly. Alternatively, there could be no time limit at all in most cases, but a time-limit of 14 days (or other agreed length) in cases where it was feared that capacity might be lost before suicide would take place. If there were any cases in which no time-limit was in operation, some system for controlling/accounting for lethal doses of drugs between the issue of the prescription and the act of suicide would need to be devised for those cases.

Consideration by other committees

Justice Committee

288. The Justice Committee was assigned as secondary committee for stage 1 consideration of the Assisted Suicide (Scotland) Bill. Its evidence-taking focused on the legal aspects and practical application of the Bill, as well its compliance with the European Convention on Human Rights.

289. The Justice Committee report has been used to inform the Health and Sport Committee’s consideration of the processes and possible practical implications of the provisions in the Bill. These issues have been discussed earlier in this report.
Delegated Powers and Law Reform Committee

290. The DPLRC report discusses Section 23 of the Bill which relates to the power conferred on Scottish Ministers to issue directions and guidance for facilitators and licensing authorities. Its recommendations were considered earlier in this report.

Finance Committee

291. In its call for evidence on the Bill, the Finance Committee sought responses to questions relating to the Bill’s Financial Memorandum. Responses were received from eight organisations. These responses are available on the Scottish Parliament’s website at the following link:

http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/75409.aspx

Summary of conclusions and recommendations

292. The Committee is not persuaded by the argument that the lack of certainty in the existing law on assisted suicide makes it desirable to legislate to permit assisted suicide; it considers that the law must continue to provide an effective deterrent against abuse, and to be responsive to the individual facts of particular cases. [Paragraph 52]

293. The Committee acknowledges that there is an ethical duty to respond with compassion to the suffering of others, as well as a need to uphold the dignity of those who are suffering at the end of life, and to avoid endorsing negative attitudes and judgments about disability, illness, and older age.

294. The Committee acknowledges that there are ways of responding to suffering (such as increased focus on palliative care and on supporting those with disabilities), which do not raise the kind of concerns about crossing a legal and ethical “Rubicon” that are raised by assisted suicide. [Paragraph 70]

295. Given the qualified nature of the principle of respect for autonomy, and the need to weigh it against other relevant legal and ethical principles, the Committee is not persuaded that the principle of respect for autonomy on its own requires that assisted suicide be permitted in some circumstances. [Paragraph 89-92]

296. Having considered assisted suicide alongside other end-of-life practices in healthcare, the Committee considers that assisted suicide is ethically and legally distinct from practices such as the cessation of life-sustaining treatment and the administration of painkilling drugs which incidentally hasten death, and that the reasons which justify these practices do not support or justify assisted suicide. [Paragraph 101 and Paragraph 110]
297. The Committee considers that experience from other jurisdictions, although informative, cannot be regarded as evidence either in favour of the Bill or against it, not only because none of the existing regimes is directly equivalent to the proposals in the Bill, but because each cultural context is distinct, so that experience from one jurisdiction cannot be extrapolated straightforwardly into another. [Paragraph 133-134]

298. It seems clear that in numerous respects, some of which go to the heart of the Bill’s purpose, the language of the Bill would introduce much uncertainty. In the context of a statute that makes an exception to the law of homicide and permits one person to assist in the death of another, such significant uncertainty must be unacceptable and would require to be addressed were Parliament to approve the Bill at Stage 1. [Paragraph 165]

299. The Committee notes the comments made by some witnesses that the Bill does not distinguish adequately between “assisted suicide” (which it seeks to legalise) and “euthanasia” (which it does not); [Paragraph 139] it does not define the criteria for eligibility sufficiently clearly; [Paragraph 147] it describes the role of the facilitator using ambiguous terminology; [Paragraph 148] and it contains a savings clause which may make prosecution difficult in cases where it would be desirable.[Paragraph 156-165]

300. The Committee considers that a requirement for mandatory psychiatric assessment would be desirable in relation to any request for assisted suicide by a person who was terminally ill, under the age of 25, and/or with a history of mental disorder. [Paragraph 181-184] The Committee also acknowledges the argument that given the magnitude of the decision to commit suicide, assessment by a psychiatrist ought to be routine in all cases. [Paragraph 168,169]

301. The Committee considers that if the Bill were to be approved at Stage 1, consideration would need to be given to measures aimed at minimising the risk of coercion; however the Committee notes that the risk of coercion can never be eliminated completely. [Paragraph 193 -194]

302. The Committee notes the views of opponents and supporters of the Bill alike that assisted suicide, even if legal, would not be “medical treatment” in the ordinary sense. The Committee notes that the Bill does not preclude the possibility of the subject of assisted suicide being raised in the first instance by the healthcare practitioner rather than by the patient. [Paragraph 206- 209]

303. The Committee acknowledges that there is demand on the part of professional bodies for protection for individual practitioners’ rights of conscience. The Committee notes the likelihood that statutory provision for conscience cannot be enacted by the Parliament, and considers that alternatives to statutory protection (such as provision in professional guidance) do not provide an equivalent level of protection to that which statute can provide. [Paragraph 221, 228]
304. The Committee understands that, were this Bill to pass into law, it would, in theory, be possible in terms of legal principle under section 104 of the Scotland Act 1998, for an order to be made by a UK Minister and laid before the UK Parliament to provide for a “conscience clause” in Scotland enabling relevant health professionals to refrain from providing assistance under the Bill on the grounds of conscientious objection. Such an order can make provisions on matters that are reserved to Westminster, in consequence of an Act of the Scottish Parliament. [Paragraph 229]

305. The Committee invites the member in charge, should the Parliament approve the general principles of the Bill, to explore the extent to which this possibility might be realistic and to report on this to the Committee in advance of Stage 2. [Paragraph 230, 231]

306. The Committee notes a number of respects in which the role of the licensed facilitator would require to be clarified were the Bill to be approved at Stage 1. Clarification would be required in terms of what counts as permissible assistance; the means by which an assisted suicide may be accomplished under the Bill; and whether the facilitator is obliged to be present at the time of the suicide/attempted suicide. [Paragraph 253]

307. The Committee considers that if the licensed facilitator is to have responsibility for attesting that the correct process has been followed in a case of assisted suicide, any legislation ought to provide that the facilitator must make every reasonable effort to be present when the act of suicide takes place. [Paragraph 255]

308. The Committee endorses the recommendation of the Delegated Powers and Law Reform Committee that there should be a requirement that, in addition to being published, any Ministerial Guidance or Directions for facilitators must be laid before the Parliament. [Paragraph 254]

309. The Committee considers that it would be preferable to require that deaths and attempted suicides under the legislation be reported to the Procurator Fiscal's office, rather than to the Police. [Paragraph 264]

310. The Committee considers that it would be preferable if provision were made for the creation of an independent supervisory body with responsibility for ingathering and checking of paperwork; collecting, analysing and publishing data on assisted suicide in Scotland; and overseeing and scrutinising the activities of licensed facilitators. The Committee considers that the creation of such a body would be essential both to safeguard the public, and to protect facilitators themselves. [Paragraph 268]

311. The Committee considers that legislation to permit assisted suicide seems discordant with a wider policy of suicide prevention, in two ways. [Paragraph 275]

312. First, because it involves differentiating between the majority of circumstances in which suicide is to be regarded as a tragedy and prevented wherever possible,
and some circumstances in which suicide is to be regarded as a reasonable choice to be facilitated and supported; this risks sending negative messages to, and about, those who would be eligible for assistance under the legislation. [Paragraph 278-280]

313. Second, because legislating to permit assisted suicide could have a corrosive effect on the central suicide prevention message by “normalising” suicide and seeming to endorse it. [Paragraph 278-280]

314. The Committee has concerns that specifying that the act of assistance must take place within 14 days of the second request being recorded may create pressure for a person to proceed with an act of suicide prematurely. [Paragraph 286, 287]

315. The Committee is also concerned at the prospect of lethal doses of drugs being dispensed into the community in an uncontrolled manner; the Committee considers that, if there were any cases in which no time-limit was in operation, some system for controlling/accounting for lethal doses of drugs between the issue of the prescription and the act of suicide would need to be devised.[Paragraph 287]

### Overall conclusions

316. The Committee notes the good intentions of the Member in Charge of the Bill and recognises the complexity of the various moral and ethical issues that consideration of this Bill presents.

317. The Committee recognises the strength of feeling expressed by those who have given evidence both in support of and in opposition to the general principles of the Bill. The Committee recommends that the Parliament approach the Stage 1 decision with due respect for this diversity of views.

318. The Committee believes the bill contains significant flaws. These present major challenges as to whether the Bill can be progressed. Whilst the majority of the Committee does not support the general principles of the Bill, given that the issue of assisted suicide is a matter of conscience, the Committee has chosen to make no formal recommendation to the Parliament on the Bill.
8 Health and Sport Committee, Official Report, Tuesday 13 January 2015, column 12.
9 Health and Sport Committee, Official Report, Tuesday 13 January 2015, column 12.
10 The Lord Advocate. Written submission. (emphasis in original).
12 Professor Pamela R Ferguson. Written submission.
13 Professor Pamela R Ferguson. Written submission.
14 Professor Pamela R Ferguson. Written submission. Professor James Chalmers. Written submission.
15 In the unreported case of Paul Brady (described by Professor Ferguson in her submission) Brady killed his brother, who had been suffering from Huntingdon’s disease. Because Brady had acted out of compassion and in response to numerous explicit requests from his brother, the Crown accepted his offer to plead guilty to culpable homicide rather than murder; the trial judge in the High Court admonished him.
16 Assisted Suicide (Scotland) Bill section 18. Policy Memorandum, paragraph 14.
17 Section 19 of the Bill refers to “any drug or other substance or means”.
18 Professor James Chalmers. Written submission, paragraph 15.
20 Although see discussion of the ‘savings clause’ paragraph 159.
21 Professor James Chalmers. Written submission, paragraph 26.
22 The Lord Advocate. Written submission.
23 Health and Sport Committee, Official Report, 13 January 2015, Col 8.
26 Scottish Unitarian Association. Written submission.
27 My Life, My Death, My Choice. Written submission.
28 Doctors for Assisted Suicide. Written submission.
29 Friends at the End. Written submission.
33 Anscombe Bioethics Centre. Written submission, page 1.
34 Concerns about fostering or entrenching negative social attitudes about those who would fall within the eligibility criteria were expressed in a number of the written submissions received by the Committee: for example, those from the Royal College of Paediatrics and Child Health; the Church of Scotland Church and Society Council; and the Anscombe Bioethics Centre.
35 Health and Sport Committee, Official Report, 3 February 2015, Col 44.
37 Health and Sport Committee, Official Report, 3 February 2015, Col 58.
38 This was emphasised, for example, in the written submissions from Evangelical Alliance Scotland, SPUC Scotland, and the Church of Scotland Church and Society Council.
41 Church of Scotland Church and Society Council. Written submission, page 1; also mentioned in Evangelical Alliance Scotland. Written submission, page 1.
42 Doctors for Assisted Suicide. Written submission, page 3.
44 Health and Sport Committee, Official Report, 3 February 2015, Col 15.
45 Health and Sport Committee, Official Report, 13 January 2015, Col 36.
48 Although the submission refers to “euthanasia”, in the context of a response to the present Bill, it is assumed that this refers equally to euthanasia and assisted suicide. Strathcarron Hospice. Written submission.
49 Strathcarron Hospice. Written submission, page 1.
be assisted to die." So, the question is whether it is morally consistent not also to reflect in law situations in which people can refuse care and die because it is their choice to do so, the question is whether it is morally consistent not also to reflect in law situations in which people can be assisted to die.

Anthony (now Lord) Lester QC in Airedale NHS Trust v Bland [1993] Appeal Cases 789 page 848 paragraph E.

This question was raised by Professor Laurie, Health and Sport Committee. Official Report, 20 January 2015, Col 15: "If we recognise the fact that people can refuse care and die because it is their choice to do so, the question is whether it is morally consistent not also to reflect in law situations in which people can be assisted to die."

Policy Memorandum, paragraph 67.

The use of the term 'mental disorder' is language taken from another statute, the Committee is not endorsing the use of the term (and notes the British Psychological Society Guidance on the use of terminology).
This is the majority view, but Professor James Chalmers believes that the position is unclear.

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Health and Sport Committee
Stage 1 Report on Assisted Suicide (Scotland) Bill, 6th Report, Session 4 (2015)

209 Living and Dying Well. Written submission, page 1.
210 Anscombe Bioethics Centre. Written submission. Scottish Council on Human Bioethics. Written submission
211 Living and Dying Well, p1. Written submission, page 1.
212 Anscombe Bioethics Centre. Written submission.
215 Policy Memorandum, paragraph 41.
217 End of Life Assistance (Scotland) Bill Committee. 1st Report, 2010 (Session 3). Stage 1 Report on the End of Life Assistance (Scotland) Bill (SP Paper 523).
Annexe A

Extracts from the minutes of the Health and Sport Committee and associated written and supplementary evidence

36th Meeting, 2013 (Session 4), Tuesday 17 December 2013
Assisted Suicide (Scotland) Bill: The Committee agreed to seek approval for the appointment of an adviser in connection with its forthcoming Assisted Suicide (Scotland) Bill.

4th Meeting, 2014 (Session 4), Tuesday 4 February 2014
1. Decision on taking business in private: The Committee agreed to take item 3 in private.
3. Assisted Suicide (Scotland) Bill: The Committee considered a list of candidates and agreed an order of preference for appointment.

8th Meeting, 2014 (Session 4), Tuesday 11 March 2014
1. Decision on taking business in private: The Committee agreed to take items 5 and 6 in private.
5. Assisted Suicide (Scotland) Bill: The Committee agreed its approach to the scrutiny of the Bill at Stage 1.
In attendance: Dr Mary Neal (Committee Adviser)

28th Meeting, 2014 (Session 4), Tuesday 4 November 2014
1. Decision on taking business in private: The Committee agreed to take items 3 and 4 in private.
4. Assisted Suicide (Scotland) Bill: The Committee agreed to defer consideration of this item.

31st Meeting, 2014 (Session 4), Tuesday 25 November 2014
Assisted Suicide (Scotland) Bill (in private): The Committee considered and agreed its approach to the scrutiny of the Bill at Stage 1.
In attendance: Dr Mary Neal (Committee Adviser)
1st Meeting, 2015 (Session 4), Tuesday 13 January 2015

1. Decision on taking business in private: The Committee agreed to take items 5, considering the main themes arising from the oral evidence heard and a draft report on the Assisted Suicide (Scotland) Bill, in private and in private at future meetings. The Committee also agreed to take item 6, a draft Stage 1 report on the Mental Health (Scotland) Bill, in private and in private at future meetings.

2. Assisted Suicide (Scotland) Bill - witness expenses: The Committee agreed to delegate to the Convener responsibility for arranging for the SPCB to pay, under Rule 12.4.3, any expenses of witnesses on the Bill.

4. Assisted Suicide (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—
   - David Stephenson Q.C., The Faculty of Advocates; Professor Alison Britton, Convenor of the Society Health and Medical Law Committee, and Coral Riddell, Head of Professional Practice for the Society, The Law Society of Scotland;
   - Gary Flannigan, Detective Chief Superintendent, Police Scotland;
   - Dr Francis Dunn, President, The Royal College of Physicians and Surgeons of Glasgow;
   - Dr Stephen Potts, Consultant Psychiatrist, The Royal College of Psychiatrists in Scotland;

5. Assisted Suicide (Scotland) Bill (in private): The Committee considered the main themes arising from the oral evidence heard earlier in the meeting.

In attendance: Dr Mary Neal (Committee Adviser)

Written Evidence

- Faculty of Advocates
- Law Society of Scotland
- Police Scotland
- Royal College of Physicians and Surgeons of Glasgow
- Royal College of Psychiatrists in Scotland
- Royal Pharmaceutical Society in Scotland

Supplementary Written Evidence

- Royal College of Psychiatrists in Scotland
2nd Meeting, 2015 (Session 4), Tuesday 20 January 2015

3. Assisted Suicide (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—
Robert Preston, Director, Living and Dying Well;
Professor Graeme Laurie, Chair of Medical Jurisprudence, Director, JK Mason Institute for Medicine, Life Sciences and Law;
Professor David Albert Jones, Director, Anscombe Bioethics Centre, Oxford;
Dr Calum MacKellar, Director of Research, Scottish Council on Human Bioethics;
Dr Stephen Smith, Lecturer in Law, Birmingham Law School.

4. Assisted Suicide (Scotland) Bill (in private): The Committee considered the main themes arising from the oral evidence heard earlier in the meeting.
In attendance: Dr Mary Neal (Committee Adviser)

Written Evidence
Anscombe Bioethics Centre
Living and Dying Well
Mason Institute
Scottish Council on Human Bioethics'
Dr Stephen Smith

3rd Meeting, 2015 (Session 4), Tuesday 27 January 2015

Assisted Suicide (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—
Dr Pat Carragher, Medical Director, Children’s Hospice Association Scotland;
Baroness Finlay of Llandaff, Palliative Care Lead Clinician for Wales and Crossbench Peer, House of Lords;
Dr Stephen Hutchison, Consultant Physician in Palliative Medicine, Highland Hospice, Inverness;
Mark Hazelwood, Chief Executive, Scottish Partnership for Palliative Care;
Richard Meade, Head of Policy and Public Affairs, Scotland, Marie Curie Cancer Care;
Dr David Jeffrey, Honorary Lecturer in Palliative Medicine, University of Edinburgh; Rev Sally Foster-Fulton, Convener, Church of Scotland (Church and Society Council);
Rev Dr Harriet Harris, Convener, Doctrine Committee, Scottish Episcopal Church (General Synod);
Rev Dr Donald MacDonald, Former surgeon and retired Professor of Theology and Ethics, Free Church of Scotland;
Ephraim Borowski, Director, Scottish Council of Jewish Communities; Dr Salah Beltagui, Member of the Standing Committee on Parliamentary Affairs, Muslim Council of Scotland; John Deighan, Parliamentary Officer, Catholic Bishops’ Conference of Scotland.

**Assisted Suicide (Scotland) Bill (in private):** The Committee considered the main themes arising from the oral evidence heard earlier in the meeting. The Committee further agreed to seek written evidence from Scots criminal law academics on the Bill.

**In attendance:** Dr Mary Neal (Committee Adviser)

### Written Evidence

- Children’s Hospice Association Scotland
- Scottish Partnership for Palliative Care
- Professor Marie Fallon and Dr David Jeffrey
- Dr Stephen Hutchison and Mrs Ingrid Hutchison
- Dr Stephen Hutchison and Dr Martin Wilson
- Highland Hospice
- Marie Curie Cancer Care
- Catholic Bishops’ Conference of Scotland
- Church of Scotland Church and Society Council
- Faith and Order Board of General Synod of the Scottish Episcopal Church
- Free Church of Scotland
- Muslim Council of Scotland
- Scottish Council of Jewish Communities

### Supplementary Written Evidence

- Dr Stephen Hutchison
- Free Church of Scotland

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### 4th Meeting, 2015 (Session 4), Tuesday 3 February 2015

**Assisted Suicide (Scotland) Bill:** The Committee took evidence on the Bill at Stage 1 from—

Jennifer Buchan, Celebrant, Humanist Society Scotland;
Dr Gordon Macdonald, Parliamentary Officer, CARE for Scotland;
Dr Peter Saunders, Campaign Director, Care Not Killing;
Dr Bob Scott, Campaign Spokesperson, My Life, My Death, My Choice;
Sheila Duffy, Press Officer, Friends at the End (FATE);
Professor Sheila McLean, Emeritus Professor of Law and Ethics in Medicine;
Dr Sally Witcher, Chief Executive Officer, Inclusion Scotland;
Catherine Farrelly, Alliance Member, Scottish Youth Alliance; 
Dr Peter Bennie, Chair of BMA Scotland, British Medical Association; 
Tanith Muller, Parliamentary and Campaigns Manager, Parkinson’s UK in Scotland.

**Assisted Suicide (Scotland) Bill (in private):** The Committee considered the main themes arising from the oral evidence heard earlier in the meeting.

**In attendance:** Dr Mary Neal (Committee Adviser)

**Written Evidence**
- British Medical Association
- CARE for Scotland
- Care Not Killing
- Friends At The End (FATE)
- Humanist Society Scotland
- Inclusion Scotland
- My Life, My Death, My Choice
- Parkinson’s UK
- Scottish Youth Alliance
- Professor Sheila McLean
- Sheila Duffy

**Supplementary Written Evidence**
- Professor Sheila McLean

**5th Meeting, 2015 (Session 4), Tuesday 17 February 2015**

**Assisted Suicide (Scotland) Bill:** The Committee took evidence on the Bill at Stage 1 from—
Patrick Harvie MSP, member in charge of the Bill;
Andrew Mylne, Head of Non-Government Bills Unit;
Louise Miller, senior solicitor, Office of the Solicitor to the Scottish Parliament;
Amanda Ward, adviser to Patrick Harvie.

**Assisted Suicide (Scotland) Bill (in private):** The Committee considered the main themes arising from the oral evidence heard earlier in the meeting.

**In attendance:** Dr Mary Neal (Committee Adviser)
9th Meeting, 2015 (Session 4), Tuesday 17 March 2015
Assisted Suicide (Scotland) Bill (in private): The Committee considered a draft report on the Assisted Suicide (Scotland) Bill Stage 1 Report. Various changes were agreed to, and the Committee agreed to consider a revised draft, in private, at a future meeting.
In attendance: Dr Mary Neal (Committee Adviser)

10th Meeting, 2015 (Session 4), Tuesday 24 March 2015
Assisted Suicide (Scotland) Bill (in private): The Committee considered a draft report on the Assisted Suicide (Scotland) Bill Stage 1 Report. Various changes were agreed to, and the Committee agreed to consider a revised draft, in private, at a future meeting.
In attendance: Dr Mary Neal (Committee Adviser)

11th Meeting, 2015 (Session 4), Tuesday 31 March 2015
Assisted Suicide (Scotland) Bill (in private): The Committee considered a draft report on the Assisted Suicide (Scotland) Bill Stage 1 Report. Various changes were agreed to, and the Committee agreed to consider a revised draft, in private, at a future meeting.
In attendance: Dr Mary Neal (Committee Adviser)

12th Meeting, 2015 (Session 4), Tuesday 21 April 2015
Assisted Suicide (Scotland) Bill (in private): The Committee considered a draft report on the Assisted Suicide (Scotland) Bill Stage 1 Report. Various changes were agreed to, and the Committee agreed to consider a revised draft, in private, at a future meeting.
In attendance: Dr Mary Neal (Committee Adviser)

13th Meeting, 2015 (Session 4), Tuesday 28 April 2015
Assisted Suicide (Scotland) Bill (in private): The Committee considered a revised draft Stage 1 report. Various changes were agreed to, and the report was agreed for publication.
In attendance: Dr Mary Neal (Committee Adviser)
List of other written evidence

Groups and Organisations

- Alzheimer Scotland
- British Association for Counselling and Psychotherapy (BACP)
- British Psychological Society
- Church and Society Committee of the United Reformed Church’s Synod of Scotland
- Community Pharmacy Scotland
- Crown Terrace Baptist Church
- Dignitas
- Dignity in Dying
- Doctors for Assisted Suicide
- Dumfries and Galloway Over 50’s Committee Meeting
- Dumfries and Galloway Over 50’s Group Meeting
- East Dunbartonshire Social Work
- East Lothian Health & Social Care Partnership
- Equality and Human Rights Commission
- Evangelical Alliance Scotland
- Fellowship of Independent Evangelical Churches’ (FIEC) in Scotland
- General Pharmaceutical Council
- Group of Palliative Care Physicians
- Islamic Medical Association/UK
- Lord Advocate
- NHS Forth Valley
- North Ayrshire Council
- Public Questions, Religion & Morals Committee of the Free Church of Scotland (Continuing)
- Reformed Presbyterian Church of Scotland
- Royal College of Paediatrics and Child Health
- Royal College of Physicians of Edinburgh
- SAMH
- Scottish Ambulance Service
- Scottish Disability Equality Forum
- Scottish Government
- Scottish Independent Advocacy Alliance
- Scottish Justices Association
- Scottish Unitarian Association
- Society for the Protection of Unborn Children
- St Margaret of Scotland Hospice
- Stirling Council
- Strathcarron Hospice
- The Salvation Army
- Together (Scottish Alliance for Children’s Rights)
- Together for Short Lives
- The World Federation of Right to Die Societies
Anonymous Submissions

Anonymous 1.
Anonymous 2.
Anonymous 3.
Anonymous 4.
Anonymous 5.
Anonymous 6.
Anonymous 7.
Anonymous 8.
Anonymous 9.
Anonymous 10.
Anonymous 11.
Anonymous 12.
Anonymous 13.
Anonymous 14.
Anonymous 15.
Anonymous 16.
Anonymous 17.
Anonymous 18.
Anonymous 19.
Anonymous 20.
Anonymous 21.
Anonymous 22.
Anonymous 23.
Anonymous 24.
Anonymous 25.
Anonymous 27.

Individual Submissions

Lois Aitkenhead
Liz Albert
Michael Alexander
George Allan
Rosemary Alpine
Gordon Anderson
John Andrew
Theresa Archibald
Nicholas and Danielle Argyris
Alina Armstrong
Mark Armstrong
Jessie Arthur
William W. Baird
Mr P Balfour
Joy Balgarnie
Agnes Balkeen
Kate Barrett
Dr Andrew Bathgate
Elspeth Baxter
T.V. Baxter
Barry Beacon-Lambert
Gordon Bell
Ann Beuken
John Bishop
Dr Val Bissland
Sandra Black
Brian E Blacklaw
Jason Blean
Dr Mary Bliss
Mary Bliss
Alan Bourne
Isobel Braceywell
Agnes M. Bradley
Peter Brawley
C Brewster
David Brogan
John Bromhall
Mary Brosman
Brian Brown
Talitha Brown
Ronald G. Brown
Paul Brownsey
Annette Brydone
Mary Teresa Burrows
Eleanor Burt
John Burton
Judy Bury
L.G. Byfield
George Caldow
Fiona Campbell-Smith
Johanna Carrie
Mary L Carson
Dr Paul Cavanagh
Josephine Cecil
James Chalmers
Steve Chinn
R Cinderey
Pamela Clark
Simon Clark
Jill Clarke
Maggie Clayton
Kathleen Clezy
Gerald Conaghan
Alistair Cook
Nick Craggs
Carole Craig
Anne-Marie Crichton
Kathleen, John and Sean Crossan
Tony Crow
Max Cruickshank
John Cullen
Sheila E Cumming
Catherine Dalgarno
Jean Darlison
James Davidson
Alison Davies
Caroline Davis
Mr Edward and Mrs Maureen Devine
Gerry Devlin
Eileen Dickie
John Dickie
James Dobson
Dr Euan Dodds
Mike Dodds
Rev Alan Donald
Janet Donnelly
David Donnison
Lydia M. Dorward
Gerardene Douglas-Scott
Pamela Draper
Dr Gordon Drummond
Martin Dunnery
Dr J A T Dyer
Marian Evans
Jim Farren
Dr Stephen Feltbower
David and Jeanette Ferguson
Mrs E Ferguson
Stuart J Ferguson
Jonathan Fisk
David Flatman
Mrs Ann Fleming
Donal Fleming
Jacquie Forde
George Forrest
Andrew Fraser
Anthony Fraser
Dr Jane Gallacher
Jim Gannon
J Gardner
NGA Gardner
Gordon Gaskell
John Gatens
Martin Gault
Claire Geddes
Joan Gibson
John Goodall
Janice Gordon
Andrew Graham
David Graham
Garry Graham
Steve Graham
Linda Grant
S Greenaway
Mrs F H Greenlaw
Dr Judith Greenwood
Ian Gregory
Peter Gunn
Sandy Gunn
L.H.
M Hadfield
John Haggerty
Douglas Hall
Janet Hamilton
Penelope Hamilton
Chris Hampton
Walter F Hannay
Janet Harbidge
Julian A. Harrison
Dr Richard C. Hartley
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Barbara Heaton
Frances Hendry
Mary Henry
Pat Heppell
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<td>Gwynne Hetherington</td>
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<td>David Higgins, St Augustine’s pro life group</td>
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<td>Veda Hill</td>
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Michael McLoone
Teresa McNally
Teresa McNeece
Veronica McNeece
Lucille McQuade
Adele McVay
Charles Maitland
Agnes Anna Mallon and Peter Mallon
Jennyfer Malyon
Caroline Manz
Professor Emeritus S. J. Martin
Mrs B Maynard
Professor Gillian Mead
Peter Mehta
William Meikle
Eric Melvin
Rhona Middlern
Chris Mitchell
Michael Mitchell
Dr Alexander T. B. Moir
Brian Mooney
Ann Moran
Dr Gareth Morgan
Neil Morrison
Peter and Marion Morrison
William Morrison
Gerald Morrow
Catriona Muir
Peter Mulheron
Ruby Mulholland
Dr Christine Murray
Katherine Naylor
Jeanne Neal
James Neil
George Neilson
Ray and Pat Newton
Liz Nichols
Michael Nisbet
Philip D. Noble (Rev Dr)
Michael A. Nolan
Martin Norval
Lorna Nunn
Ged O’Brien

David O’Neill
Deirdre O’Reilly
Alex Orr
Catherine Owen
Lucy Mackenzie Panizzon
Margaret Pattinson
George and Margaret Paxton
Duncan Peters
Moira Pfusch
Calbert and Christina Phillips
Dr Joan Picozzi.
Pearl Prisley
Robert Proudlove
John N E Rankin
Claudine Raulier
John and Jean Raven
John Reid
Kyle Reid
Jean Rennie
Dr Joanne Renton
Annie Rhodes
Alan Richardson
C Richardson
Bert Rima
Maria Robertson
Frances Robson
Alison Joan Rodgers
Marie Rodgers
Ian Rolfe
Karen Rookwood
Jean Rooney
C.Brian Ross
Christopher G Ross
Graham Ross
Irene Roxburgh
G Rushforth
Briony Savage
Joe Schofield
David Scott
Dr Robert Scott
Marjoy Scullion
Dev Sewnauth
Stephen Shaw
Emilie Sinclair
Patricia Sinclair
Robert Sinclair
Georgina Singleton
Christine Smith
David Smith
Dawn Smith
Helen Smith
Ian Smith
Ian Smith
Scott Smith
Thomas Smith
Dr Eleanor Steiner
Dr David Stevenson
Allan Stewart
Ewen Stewart
Dr June Stewart
Dr Margaret E Stewart
Vivien Stewart
Donella Stirling
Hilary Stuart
Iain Stuart
Moira Symons
Colin Tawse
Rab Taylor
Thomas and Kathleen Thompson
Jean Tobin
Lorna Ventry
Ian Waddell
Niall Walker
Dr John Walley
Joseph Walsh
Christopher Ward
Dr Charles Warlow
Lesley Warren
Lesley Warren
Eunice Watson
Helen Watt
Linsday Watt
Mary Watt
Stephen Watt
Tom Webster
Stuart Wight
David Wilde

Mairi Wilkie
Graham Wilson
Jean Wilson
Brian Wood
Hugh Wynne
Gwendolyn Young

Late Submissions
Douglas Niven
Rudi Vogels
Mrs Janette Montgomery
Miss June Clunie
WF Morrison Dorward
General Medical Council

Supplementary Evidence
The Lord Advocate
Anscombe Bioethics Centre
Doctors for Assisted Suicide
Free Church of Scotland (Continuing)
Lydia M. Dorward
Iain C Kerr

Evidence Requested by Committee on Clarity of Current Law
Professor Pamela R Ferguson
Professor James Chalmers
My Life, My Death, My Choice

The 416 individuals listed below all sent in identically worded submissions with the following text.

I am writing to you in your role as an MSP who is a member of the Health & Sport Committee of the Scottish Parliament which is currently taking evidence on Stage 1 of the Assisted Suicide (Scotland) Bill.

I believe that individuals should be able to choose to have assistance to commit suicide if they are suffering from a terminal or life-shortening condition. This view is supported by 69% of people in Scotland according to a recent independent poll commissioned by the My Life, My Death, My Choice campaign.

The Bill provides strong safeguards to ensure that vulnerable individuals cannot be coerced in any way to take action and ensures that Doctors who object to the process cannot be forced to be involved. I believe this approach balances the desire of some to be given the option to have assistance to commit suicide whilst respecting the wishes and beliefs of those who may disagree.

I hope your report will recommend that the Scottish Parliament approve the Assisted Suicide (Scotland) Bill when it comes before the Chamber.

Annexe B

Report and correspondence from the Delegated Powers and Law Reform Committee, Finance Committee’s call for evidence on Financial Memorandum and Report from the Justice Committee

The Delegated Powers and Law Reform Committee (DPLRC) report on the Assisted Suicide (Scotland) Bill can be found on the Scottish Parliament’s website at the following webpage:

http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/86434.aspx

Correspondence between DPLRC, the Member in Charge of the Bill and the Committee:

http://www.scottish.parliament.uk/S4_SubordinateLegislationCommittee/2014-12-09_Clerk_to_Patrick_Harvie_MSP.pdf
http://www.scottish.parliament.uk/S4_SubordinateLegislationCommittee/20141217_PH_letter__.pdf

Letter from the Convener of the DPLRC to the Convener:

http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Assisted%20Suicide%20Bill%20submissions/Lettter_from_DPLR_Convener_to_Committee.pdf

Justice Committee: Report to the Health and Sport Committee on the Assisted Suicide (Scotland) Bill

http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/85275.aspx

Finance Committee’s call for evidence on Assisted Suicide (Scotland) Bill Financial Memorandum

http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/75409.aspx