ASSISTED SUICIDE (SCOTLAND) BILL

MARGO MACDONALD

SUMMARY OF CONSULTATION RESPONSES

This document summarises and analyses the responses to a consultation exercise carried out on the above proposal.

The background to the proposal is set out in section 1, while section 2 gives an overview of the results. A detailed analysis of the responses to the consultation questions is given in section 3. These three sections have been prepared by the Scottish Parliament's Non-Government Bills Unit (NGBU). Section 4 has been prepared by Margo MacDonald MSP and includes her commentary on the results of the consultation.

Where respondents have requested that certain information be treated as confidential, or that the response remain anonymous, these requests have been respected in this summary.

In some places, the summary includes quantitative data about responses, including numbers and proportions of respondents who have indicated support for, or opposition to, the proposal (or particular aspects of it). In interpreting this data, it should be borne in mind that respondents are self-selecting and it should not be assumed that their individual or collective views are representative of wider stakeholder or public opinion. The principal aim of the document is to identify the main points made by respondents, giving weight in particular to those supported by arguments and evidence and those from respondents with relevant experience and expertise. A consultation is not an opinion poll, and the best arguments may not be those that obtain majority support.

Copies of the individual responses are available on the following website http://www.margoforlothian.com/news/assisted_suicide_consultation_responses.html. Responses have been numbered for ease of reference, and the relevant number is included after the name of the respondent.

Lists of respondents are set out in the following

- Annexe A - List of individual responses (numbered as received)
- Annexe B – List of organisations (numbered as received)
- Annexe C - List of organisations (alphabetical)

SECTION 1: Background

1. Margo MacDonald MSP's draft proposal, lodged on 23 January 2012 is for a Bill to:

> enable a competent adult with a terminal illness or condition to request assistance to end their own life, and to decriminalise certain actions taken by others to provide such assistance.

2. The proposal was accompanied by a consultation document, prepared with the assistance of NGBU. This document was published on the Parliament's website, from where it remains accessible: http://www.scottish.parliament.uk/parliamentarybusiness/Bills/29731.aspx.

3. The consultation period ran from 23 January to 30 April 2012. There were a small number of late replies; however, in line with the specified closing date, these were not included in the final analysis.

4. In total 149 organisations and individuals were sent copies of the consultation or links to it. These organisations included Local Authorities, Health Boards, a wide range of Churches and religious organisations, doctors' and nursing organisation as well as a range of voluntary and charitable groups.

5. The consultation period was launched with a press conference held on 23 January which was attended by a wide cross section of newspaper, TV and radio journalists.

6. The consultation exercise was run by Margo MacDonald's parliamentary office.

7. The consultation process is part of the procedure that MSPs must follow in order to obtain the right to introduce a Member's Bill. Further information about the procedure can be found in the Parliament's standing orders (see Rule 9.14) and in the *Guidance on Public Bills*, both of which are available on the Parliament's website:
   - Standing orders (Chapter 9): http://www.scottish.parliament.uk/parliamentarybusiness/26514.aspx
   - Guidance (Part 3): http://www.scottish.parliament.uk/parliamentarybusiness/Bills/25690.aspx

SECTION 2: Overview of responses

8. The following tables set out the number of responses received and the level of support for the proposal. With regard to the latter, information has been drawn from the responses generally and the answers given to question 1 of the consultation paper. Responses have been separated into two groups, organisations and individuals. It is not intended that any additional weight be given to any particular grouping.

Responses received from organisations

Breakdown of organisations

Category	**Number**	**% of total Organisations**
Religious organisations	18	33%
Palliative care organisations (including providers such as hospices and representative bodies)	8	15%
Bodies representing medical professionals (GPs, pharmacists, physicians and nurses)	6	11%
Pro-life groups	5	9%
Pro-choice groups	4	7%
Local authorities	4	7%
Equality representative groups	3	5%
NHS organisations	2	4%
Organisations representing people with particular medical conditions	2	4%
Medical ethics/education bodies	2	4%
Community organisation	1	1%
Total	**55**	**(6% of all responses received)**

	Organisations
For	5 (9%)
Against	34 (62%)
Neutral / Undecided / No Clear View	16 (29%)

9. A number of organisations did not offer a view, but circulated the consultation to their members for them to answer as it was seen as an individual matter of conscience. Other organisations consulted members and received a wide variety of views which made it difficult to respond with any overall view.

10. Twenty organisations (36%) did not answer any of the questions; of these 14 were opposed, 5 held no view and 1 was supportive. Fourteen of the 20 organisations presented arguments to support their view (mostly those opposed), while the remaining 6 organisations made no comment on the proposed Bill except to record a view.

Responses received from individuals

Breakdown of individual responses

11. It is not possible to categorise all of the individual respondents. However, they included:
    - members of the medical profession including doctors, GPs, nurses, a consultant clinical psychologist and a psychiatrist
    - retired GPs and a geriatrician
    - palliative care doctors and a nurse
    - a care assistant
    - a worker in the field of Grief and Loss education
    - a volunteer and worker in a hospice
    - a retired police officer
    - Church of Scotland ministers
    - a professor of medical neurology
    - a priest
    - a chaplain
    - a psychic.

12. Personal views were expressed on creating a Living Will, about being disabled and living in a retirement development. A number of individual respondents wrote in agreement with pro-life groups, such as Care not Killing Alliance Scotland, SPUC Scotland, CARE for Scotland, Catholic Parliamentary Office, Pro Life Alliance and Christian Medical Fellowship (Scotland) and pro-choice groups, like Friends at the End (FATE) and Dignity in Dying.

FOR (total) – of which:	276 (35% of individual responses)
• Substantive responses (expressing the individual views of the respondent)	199 (72% of those in support)
• Standard responses (expressing standard arguments suggested by campaign groups)	0
• Notes of support (no arguments given)	77 (27% of those in support)
AGAINST (total) – of which:	512 (64% of individual responses)
• Substantive responses (expressing the individual views of the respondent)	85 (17% of those opposed)
• Standard responses (expressing standard arguments suggested by campaign groups)	165 (32% of those opposed)
• Notes of opposition (no arguments given)	262 (51% of those opposed)
NEUTRAL/UNDECIDED/NO CLEAR VIEW	5 (1% of individual responses)
TOTAL	**793 (94% of all responses received)**

13. As can be seen from the table 77 people wrote only to express their support and a further 262 only to state their opposition to the aim of the proposed legislation. These respondents did not answer any of the consultation questions.

14. Of the 512 individual responses against the proposal, 165 repeated the same arguments raised by campaign websites and these arguments have been included within the summary. 13 of these respondents stated they supported the views in the Care Not Killing response to the consultation.

15. Of the substantive responses (199 for and 85 against) 57 (20%) gave examples of their personal experiences which varied from those who had been diagnosed with terminal illness to people who had experienced a family member or close friend going through the various stages of a terminal illness.

16. Two respondents who supported the proposal had relatives who had gone to Dignitas.

17. Sixty-six (22%) of the individuals who responded advised they had a medical background and, of these, 17 (26%) supported the proposals, 46 (70%) were against and three (5%) were either undecided or neutral.

Total responses received

18. Taking organisations and individuals together, there was a total of 848 responses to the consultation. Nearly two-thirds of respondents were opposed to the proposal, while one-third expressed support for the proposal.

For	281 (33%)
Against	546 (64%)
Undecided / neutral / no clear view	21 (3%)
TOTAL	**848**

19. A much larger proportion of organisations did not express a clear view in favour or against, compared with the individuals.

20. Also to be noted is the large proportion of non-substantive individual responses (i.e. they either give no reasons for supporting/opposing the Bill, or at best adopt other people's reasons without giving their own). If these responses were discounted, the result would look very different: of the 344 substantive responses, 204 (5 organisations + 199 individuals) were in **favour (59%)**; 119 (34 organisations + 85 individuals) **against (35%)** and 21 (16 organisations + 5 individuals) **neutral/undecided (6%)**.

21. This summary, undertaken by the Non-Government Bills Unit, makes no attempt to draw conclusions from these factors. The points highlighted are to assist transparency and to help the reader in understanding the summary.

SECTION 3: Responses to individual questions

22. This section sets out an overview of responses to each question in the consultation document.

23. Respondents to the consultation document were invited to answer ten questions.

24. The first question considers the general aim of the proposed legislation, while the others relate mainly to the detail of how assisted suicide is to be provided for.

25. A number of respondents only answered the first question as they objected to the proposed Bill in its entirety. Others, although against the Bill in principle, answered some of the questions but advised that in doing so this in no way meant they endorsed the proposed Bill.

GENERAL AIM OF THE PROPOSED BILL

26. Pages 6 and 12 of the consultation document outlined the aim of the proposed Bill and what it would involve. Respondents were asked:

Q1. Do you support the general aim of the proposed Bill (as outlined above)? Please indicate "yes/no/undecided" and explain the reasons for your response.

27. A variety of reasons for supporting the general aim were provided:

- competent adults can decide legally the time and circumstances of their own passing with dignity, giving patient autonomy and relieving mental anguish
- not all would need to use the process, but they could all take assurance from its availability
- amendments to the proposed bill to address concerns of doctors (i.e. no longer required to assist)
- the "slippery slope" argument has been addressed by means of the pre-registration requirement
- if you have money and can afford it you could go to Switzerland and receive a dignified end – the proposed bill would mean no need to leave Scotland which would be an advantage for anyone physically unable to travel
- palliative care is not always as effective as the medical profession would have us believe. Drugs could help control pain but not the other unpleasant sources of suffering i.e. breathlessness, blindness, deafness and confusion
- the Bill draws on best practice experience elsewhere
- the Living Will did not progress a person's wishes far enough
- currently human rights were being denied.

28. Reasons against the general aim:
    - we do not have the right to end our own lives
    - making laws in response to a very few highly traumatic and heart-rending examples virtually always results in bad law
    - it would put vulnerable people at risk of a premature death

- it would put pressure on the elderly, disabled and frail for economic reasons in the current climate (make them feel a burden)
- it would take us down the same path as legalisation of abortion has taken – which is now on demand
- GPs and medical staff should not be made to feel they have to participate with legislation if it is against their beliefs – they have an oath to protect life
- it threatens the trust within the doctor-patient relationship
- the proposed conscience clause for doctors and pharmacists is far too restrictive
- it would be a "slippery slope" or "thin end of the wedge" leading to voluntary euthanasia
- the number of British people travelling abroad to commit assisted suicide is very small (150 in ten years)
- palliative care is not cheap but any intolerable suffering is an indictment of failure of care (good palliative care and appropriate medication can handle issues of comfort particularly with increasing advances in palliative care to relieve pain, suffering and anxiety)
- change in the law would result in major difficulties for palliative care practitioners
- assisted suicide is a cheap alternative to excellent palliative care but morally unacceptable
- breaches a fundamental human right – the right to life.

ADVANTAGES / DISAVANTAGES OF LEGISLATING

Q2: What do you see as the main practical advantages of the legislation proposed? What (if any) would be the disadvantages?

Advantages

29. The list below sets out the advantages highlighted by individual respondents. Some of these points are expanded on further in the following paragraphs with reference to particular individuals or organisations.

- autonomy and choice
- the measures proposed appear to be a good method of ensuring no-one is persuaded, influenced or otherwise enticed to take up option of assisted suicide
- bill has necessary safeguards for the vulnerable
- the elimination of criminal prosecution for assisting in suicide.
- there would be fewer botched suicides and patients would be able to discuss the matter openly with their GP and receive proper information
- would give a small group a choice – not an obligation nor a requirement but a choice
- properly regulated legal structure gives clarity for everyone
- that guidelines/safeguards once put in place should minimise any abuse for individual and facilitators
- people would have an insurance policy to "opt out" by pre-registration
- that it was important that a doctor or medical staff should not be forced to participate
- palliative care is expensive so should not be imposed on those who do not want it

Autonomy and choice

30. Most individuals who supported the proposed Bill considered patients' autonomy to be of fundamental importance. One respondent (68) summed this up in simple terms stating, "It would allow people to end their life how and where they wished." Another respondent (29) explained "People whose faith means they would not consider assisted suicide must not feel threatened".

31. Dignitas (10), a Swiss assisted dying group which helps those with terminal illness and severe physical and mental illnesses to die assisted by qualified doctors and nurses, believed the main advantage of the proposed legislation was that it would give individuals the right to decide on the time and manner of their end of life. Dignitas pointed to a number of recent legal cases in its response which it believed confirmed personal autonomy as an important principle under Article 8 of the European Convention on Human Rights and, that someone's decision to determine how their life will end was part of the right to self-determination which is protected by Article 8.

32. Friends at the End (FATE) (55) also expressed the view that the proposed bill would allow a person to choose the place they wished to die (home, hospice or hospital), and whether they wanted their friends and family to be with them. FATE also pointed out that the person could live longer as they would not need to travel abroad (while still fit enough to travel) to have an assisted suicide.

33. Another advantage was seen to be that it respects the autonomy and choice of medical professionals, as there was no compulsion to participate.

Legalising assisted suicide

34. Both the Humanist Society of Scotland (8) and the Scottish Episcopal Church (35) believed the ability to relieve intolerable suffering within the law was the key practical advantage of the proposed legislation. Currently anyone who sought to alleviate a loved one's suffering by assisting their suicide would face the threat of prosecution and this would be an additional stress for someone wishing to die.

Sufficient safeguards

35. Dignity in Dying (5) is a campaigning group for greater choice, control and access to high quality services at the end of life. It considered the main advantage of the proposed legislation was it would address the existing situation where people were taking their own lives by themselves or with amateur assistance or by travelling to Switzerland, to provide a legal, safeguarded system.

36. Responses by individuals (3 and 8) highlighted that the proposed bill had sufficient safeguards for vulnerable people with measures to ensure no-one was persuaded, influenced or otherwise enticed to take up the option of assisted suicide when it was not their choice.

Preserving dignity

37. The Scottish Youth Parliament (24) debated the proposal to legalise assisted suicide. Out of the 99 members who voted on the motion concerning the proposal 77 agreed, 21 disagreed and seven voters abstained. A recurring theme amongst the MSYPs who spoke in favour of assisted suicide was that the proposal would enable someone to die with dignity, rather than having to experience a long drawn out process.

Enables openness and ability to plan

38. Stirling & Clackmannanshire Shared Services (26) stated “It enables people to openly discuss options with friends and family, plan the future of those left behind and manage financial situations. It also allows people to feel they were able to support their loved ones wishes with no recriminations”. A former GP (67) advised “It was sometimes the case that events unfolded fairly quickly to overwhelm the patient’s coping mechanism and if so the delay between the first and second requests might cause distress. However no system will be perfect and it might be that new legislation might encourage people to be more open about their feelings and declare them earlier in the course of an illness.”

Progress of society

39. One individual (103) believed the legislation “would represent a positive landmark in societal evolution and human rights in this country.”

No disadvantages

40. A number of individuals, 44 in total, considered there were no disadvantages associated with the proposed Bill; one (11) adding that anyone who disagreed with assisted suicide could opt out. Three organisations also considered there to be no disadvantages. The Humanist Society of Scotland (8) was not aware of any shortcomings. Its view was the proposed legislation was simply trying to provide a choice. Dignitas (10) did not see any disadvantages from legislation which was aimed at respecting and implementing values of humanity. The Royal College of General Practitioners (28) stated that the legislative framework and assessment process would provide protection for both patients and the medical profession.

Disadvantages

41. The list below sets out the disadvantages highlighted by respondents. Some of these points are expanded on further in the following paragraphs with reference to particular individuals or organisations.

- people would have to officially address this issue ahead of time and may leave it too late
- it may become an elderly person’s "social duty""
- it opened the door to abuse of the vulnerable
- disabled people may feel stigmatised resulting in a sense of low self worth
- may divert funds from palliative care
- "voluntary" euthanasia would lead to cost cutting in the financing of care homes
- unscrupulous relatives heavily in debt could use the legislation to coerce a person into an assisted suicide for financial gain
- medical practitioners may be influenced by their own personal judgement and may not be keen to follow through the process of the formal requests
- two formal requests may be cumbersome
- may distort role of healthcare staff giving them an alternative to providing the best possible care (would compromise patient care)
- change medical ethics and undermine good medical practice

- the omission of an assessment by a psychiatrist was of concern
- it would require extensive training, support, supervision and mentoring for those doctors and facilitators involved in the process, particularly in its initial stages
- this proposal makes it much more difficult to disseminate a consistent and coherent anti-suicide message

A religious faith

42. Seventy-four individuals advised that their response was based either wholly or partially on religious beliefs.

43. Many religious organisations objected to the proposed Bill because it conflicted with their faith. The Free Church of Scotland (12), the Scottish Christian Party (13), the Muslim Council of Scotland (14), the Evangelical Alliance Scotland (15), the Nurses' Christian Fellowship of Scotland (27), the Methodist Church in Scotland (31) and the Catholic Parliamentary Office (34) shared the view that it was morally wrong to take one's life (those who seek assisted suicide) or to help another person to take his or her own life (those who assist suicide).

44. In addition, the Scottish Christian Party (13) also highlighted its concern that legislation could promote a 'culture of death' which it believed began when abortion was legalised. The organisation considered there was a "growing utilitarian attitude towards human life" and that only by holding onto Christian ethics could the emergence of a "duty to die" culture be prevented.

Potential impact on disease specific support services, hospices and palliative care

45. Alzheimer Scotland (19) raised concerns about the possible unintended impact any Bill might have on those with dementia. The organisation argued the stigma attached to dementia and the lack of support services available could influence any decision to die made by a person with dementia. Therefore Alzheimer Scotland believed changing the law could have the effect of endorsing discrimination and adversely affecting investment in dementia care services.

46. Although the Scottish Partnership for Palliative Care (39) was constitutionally not able to adopt an overall view on the proposed legislation, it was concerned the proposal could damage practice and provision of palliative care which currently benefits many thousands of people in Scotland each year. St Columba's Hospice (16) believed the legislation would lead to the public's perception of hospices altering. Potential patients could fear going into a hospice in case their lives were shortened. The Hospice (16) also considered "some patients might choose assisted suicide without having the opportunity to explore specialist palliative care as an alternative." St Andrew's Hospice (32) said that requests for euthanasia or assisted suicide were rare as patients in a palliative, caring environment had their on-going concerns addressed.

47. The Muslim Council of Scotland (14) stated in its submission the general public saw assisted suicide as a cheaper option rather than dealing with the seriously ill. Inclusion Scotland (22) advised that all studies showed not wanting to be a burden as the principal reason to seek death. It stated that ending a severely disabled or terminally ill person's life would be significantly cheaper than providing care and support - enactment of the proposed bill would start an accepted culture of mercy killing of disabled people.

Potential impact on equality

48. Some respondents expressed concern about discrimination towards people with disabilities. In particular those who were against the legislation from The Scottish Youth Parliament (24) had concerns that people with terminal conditions or with disabilities might feel pressured to opt for assisted suicide because they felt they were a burden to a loved one. One MSYP who expressed concern said "I think the problem is going to be this societal expectation going forward that if you are someone who needs support from other people, you are a burden and you have a responsibility to stop being a burden …."

49. One individual (53) felt the proposed legislation opened the door to abuse of the vulnerable, while another (51) considered it might become an elderly person's "social duty" to request assisted suicide in order to spare their family the burden of care. Inclusion Scotland (22) considered the proposal did not contain sufficient safeguards to ensure mental ill-health would be accounted for.

Bill title

50. Although not highlighted as a disadvantage, Stirling & Clackmannanshire Shared Services (26) was concerned about the name of the proposed bill because in the majority of reported suicide cases there were usually mental health issues, and although it accepted that processes would be put in place to ensure that the person was of sound mind, Stirling & Clackmannanshire Shared Services felt another term would be less stigmatising.

ELIGIBILITY CRITERIA

51. Page 12 of the consultation paper sets out the eligibility criteria, namely that a person must:
    - be capable (i.e. have the mental capacity to make an informed decision – using the definition established by the Adults with Incapacity (Scotland) Act 2001)
    - be registered with a medical practice in Scotland
    - be aged 16 or over
    - have either a terminal illness or a terminal condition
    - find their life intolerable.

52. The question was asked:

Q3: Do you consider that these suggested eligibility requirements are appropriate? If not, please explain which criterion or criteria you would like to see altered, in what ways, and why.

Support for eligibility criteria

53. Fifty-six individual respondents considered the suggested eligibility requirements to be appropriate. Of the organisations responding to this question five agreed with the suggested eligibility criteria, including for example, the Humanist Society of Scotland (8), Community Pharmacy Scotland (52) and Friends at the End (55).

Criticisms of eligibility criteria

54. Forty-four responses would have liked the eligibility requirements to be widened to include:
    - those suffering severe distress from incurable mental impairment, provided an intention had been expressed by the sufferer well before the onset of the illness
    - those with a non-progressive condition
    - those permanently physically incapacitated to such an extent as not to be able to live independently

55. Eleven individual respondents did not agree with the eligibility criteria. One expressed major concerns for the protection of the elderly. Another felt that even very strict eligibility criteria would be open to misuse and get eroded over time. Seven organisations did not agree with the suggested criteria, including the Scottish Council on Human Bioethics (7) and Dignitas (10).

56. Three individual respondents considered there should be no criteria for eligibility – assisted suicide should be a right for everyone.

First Criterion - capacity

57. Six organisations raised concerns about this criterion.

58. Inclusion Scotland (22) stated in its view the definition of legal capacity as used by the Adults with Incapacity Act (2001) was not a sufficient safeguard without a psychiatric evaluation, particularly where a patient was not known to the doctor involved. St Columba's Hospice (16) considered an assessment of capacity might miss a patient with depression or mild cognitive impairment. Motor Neurone Disease (Scotland) (17) explained around 10% of MND sufferers would go on to develop Frontotemporal Dementia (FTD) and that up to 50% of MND patients who did not meet the formal diagnostic criteria for dementia would exhibit some form of cognitive impairment which would not necessarily be picked up under the Adults with Incapacity Act definition.

59. Concerns were expressed by Strathcarron Hospice (44) about the removal of the requirement for a compulsory psychiatric assessment; it was felt a psychiatric assessment would help to establish a more consistent and effective method for assessing both capacity and avoiding coercion of people making the decision. One individual shared this view (519) “as a GP…. It seems like a less robust system taking away a specialist psychiatry opinion, given that the area of capacity can be so complex.”

Second criterion - registered with GP practice in Scotland

60. Royal College of Physicians of Edinburgh (25) believed the requirement for a patient to have been registered with a medical practice in Scotland seemed restrictive as it did not allow for registration with a medical practice in the UK for patients who had moved from England, Wales or Northern Ireland to be looked after by family or friends living in Scotland.

61. The Royal College of General Practitioners (28) considered the legislation should specify a minimum amount of time a person was required to be registered with a medical practice in Scotland to avoid the potential for “health” tourism.

62. The Medical Education Trust (30) was also concerned that if the bill became law non-resident individuals who considered their lives intolerable could enter the country legally and obtain temporary registration with a GP willing to prescribe lethal drugs. This could provide a business opportunity for anyone willing to facilitate this practice.

Third criterion - being aged 16 or over

63. Thirty-four individuals stated 16 years old was too young to seek assisted suicide and suggested either 18 or over, or 21 or over, would be more appropriate. Two individual respondents agreed with the age threshold set, while one respondent suggested including those under 16 years old.

64. Dignity in Dying (5), St Columba's Hospice (16), SPUC Scotland (23), St Andrew's Hospice (32), the Salvation Army (43) and Crown Terrace Baptist Church Aberdeen (51) felt that 16 was too young and that at this stage in their lives teenagers were often very impressionable and vulnerable. Two of these organisations (Dignity in Dying and the Crown Terrace Baptist Church Aberdeen) suggested that 18 was more appropriate as a minimum age.

65. One organisation explained age was not the only determinant of the ability of a young person to make decisions. Together for Short Lives (33) advised the age of legal mental capacity to give consent was not the same as the age at which an individual achieved the cognitive and emotional ability to make a decision. It suggested, as it was such a serious decision, a higher bar should be set. The onus should be on the individual to provide sustained competence verified by an appropriate professional.

66. One organisation sought to have the under 16s included. Dignitas (10) referred to a terminally ill patient who was suffering but only aged 15 and therefore could not ask for an assisted suicide.

Forth criterion - having a terminal illness or terminal condition

67. 30 individual respondents commented the terminology was not specific enough and they were troubled by the difficulty in defining "terminal illness" and "intolerable". They believed the terms and definitions used lent themselves to confusion and could at times be contradictory. Many referred to the terms used as vague, imprecise and ambiguous and explained a condition could be incurable without being terminal. An individual explained (365) "The focus on only terminal illnesses or conditions is too narrow as some chronic illnesses and conditions could make life intolerable for many."

68. 18 organisations did not support the definition of "terminal illness or a terminal condition" as it was not defined clearly enough, including for example, St Columba's Hospice (16), Christian Concern London (18), Alzheimer Scotland (19), Church of Scotland (21), Inclusion Scotland (22), Royal College of Physicians in Edinburgh (25), Stirling & Clackmannanshire Shared Services (26) Royal College of General Practitioners Scotland (28), and St Andrew's Hospice (32) which believed the definition of 'terminal condition' needed to be clarified. Scottish Partnership for Palliative Care (39) suggested it could be more meaningful to speak of an individual reaching "a terminal phase of their illness".

69. Dignitas (10) had concerns that the criterion regarding terminal illness was too restrictive as it did not include patients who were paraplegics, had Parkinson's or

individuals suffering from mental illness and their right to self-determination. Although the criterion was tighter than the previous Bill by restricting it to terminal illness or condition, Inclusion Scotland (22) advised all people with a terminal illness or condition were considered disabled under the qualifying criteria for Disability Living Allowance.

70. MND (Scotland) (17) asked if there was going to be a list produced of what was classed as a 'terminal illness' as given the prognosis of Motor Neurone Disease those diagnosed will automatically meet the criteria, however it was possible for people to be given the wrong diagnosis.

Fifth criterion – finding life intolerable

71. Ten organisations considered that finding life 'intolerable' was a subjective term and therefore difficult to express in law.

72. Of the individuals who responded one suggested adding to the 'intolerable' criteria the words "and/or the person judges the quality of their life unacceptable" as quality of life was a more personal articulation of unacceptability. While another proposed adding in 'or suffering symptoms of comparable gravity' to perhaps clarify this criteria in a more appropriate, equitable and accessible way. The Royal College of Physicians of Edinburgh (25) also believed 'intolerable' was open to interpretation. It referred to the House of Lords Select Committee consideration of Lord Joffe's bill which suggested "unrelievable" or "intractable" suffering or distress was a better description.

73. The Royal Pharmaceutical Society Scotland (9), Stirling & Clackmannanshire Shared Services (26), St Columba's Hospice (16), the Royal College of General Practitioners Scotland (28) and Christian Concern London (18) asked for clarification of the term 'intolerable' because the term was subjective or too vague. The Royal Pharmaceutical Society Scotland (9) considered guidance might be necessary to support doctors in their discussions with patients where requests were made.

74. St Andrew's Hospice (22) also agreed the term was subjective and explained that people can have periods where life becomes intolerable only for it to improve dramatically within a short period of time.

Other suggestions

75. The Scottish Partnership for Palliative Care (39) and Strathcarron Hospice (44) suggested that 'the absence of undue influence' should be listed as an eligibility criterion. In addition, the Scottish Partnership for Palliative Care (39) suggested any legislation should be clear whether a patient requesting assistance should have a right of appeal should they be assessed as ineligible and what the process for any appeal might be.

PRE-REGISTRATION

Q4: What is your general view on the merits of pre-registration? Do you have any comments on what pre-registration should consist of, and on whether it should be valid for a set period of time?

Merits of pre-registration

76. Nine organisation agreed on the merits of pre-registration with the following suggestions:
    - with organisation rather than a doctor
    - refresh every five years
    - in accordance with nationally agreed guidelines using a standard format
    - should consider a time-limit between pre-registration and the first request.

77. The Humanist Society Scotland (8) saw the pre-registration system as demonstrating "the utmost respect to those who could not bring themselves to consider the option of ending their own life". Also supportive of this approach were the Royal Pharmaceutical Society (9), Community Pharmacy Scotland (52) and the Royal College of Physicians of Edinburgh (25) as it provided evidence of a person's views on assisted suicide.

78. Individuals who responded to this question highlighted benefits such as:
    - it was an important safeguard for vulnerable people
    - pre-registration shows intent
    - the GP knows the "mind set" of the patient
    - it allows the patient to explore other methods of care management
    - it gives relatives time to adjust to the decision
    - it allows the patient to lodge a declaration, as in the case of a Living Will, before the ability to communicate or establish mental capacity is lost – shows intent.

Against pre-registration

79. Eleven organisations disagreed with pre-registration. SPUC Scotland (23) believed pre-registration didn't add any substantial safeguard to the process as there was still potential for a person to be coerced into registering. It also risked becoming a tick box process. In addition, SPUC Scotland pointed out that it was notorious how few people signed up for organ donation and therefore the idea was fanciful.

80. Neither Dignitas (10) nor Dignity in Dying (5) was in favour of pre-registration, considering it to be an unnecessary step. Both supported a system similar to Oregon where patients can initiate a discussion with their doctor at any time they wish. Dignitas (10) also did not agree that an individual should be registered with a medical practice as the pre-registration process might take place when the patient was still perfectly healthy and might not have a relationship with a GP. The Scottish Council on Human Bioethics (7) believed a pre-registration system could in fact pressurise vulnerable people to consider assisted suicide.

81. Issues raised by individual respondents against pre-registration:
    - it would cause unnecessary anxiety to many patients having to consider their options well in advance
    - it could be seen as a "tick the box" process
    - pre-registration cannot guard against coercion
    - it would increase the workload for GPs
    - it would prevent those with a short prognosis from being able to have an assisted death.

Regular review of pre-registration

82. The Royal College of Physicians of Edinburgh (25) believed pre-registration should be regularly reviewed on the patient's records to ensure the pre-registration document still reflected the patient's wishes. This view was shared by MND Scotland (17). Community Pharmacy Scotland (52) believed it might be sensible to refresh registration status every 5 years. Consideration might also be given to increasing the level of recording once a patient reaches 70 as capacity in some instance starts to become impaired. A patient of that age was also more likely to have a long term condition such as hypertension requiring review at least annually.

83. Individuals who responded to this question agreed renewal should happen periodically and suggested other time limits:
    - an online system where the patient would renew their intent every year
    - every 2-4 years
    - every 5 years
    - every 10 years.

84. Friends at the End (55) believed, however, that pre-registration should be without a time-limit for review. This was supported by two individuals, one of whom explained that pre-registration did not need to be reviewed as it does not commit anyone to act on it.

Implementation

85. People First (Scotland) (38) raised concerns about how people with learning difficulties would understand what the pre-registration process was about. While Stirling & Clackmannanshire Shared Services (26) considered pre-registration might be difficult for many people as 'where there's life there's hope' feelings could remain.

Witnessing declaration

86. Royal Pharmaceutical Society Scotland (9) believed having an independent witness was an essential part of the process. One respondent thought there might be concerns in relation to using witnesses, as some patients might prefer privacy when making decisions.

87. MND Scotland (17) and St Columba's Hospice (16) were unclear how a witness would assess whether there was no undue influence.

88. In relation to who can act as a witness, one individual suggested it should be acceptable for a witness to be a 'minor' beneficiary (i.e. left books or a memento). Another individual highlighted that the definition of 'relative' needed to be clarified to describe how closely related a person had to be before being discounted as a witness.

Other suggestions

89. Dignitas (10) suggested pre-registration could be with, for example, the Scottish Government Health Directorate – or, to match the Swiss model, an organisation similar to Dignitas, such as Friends at the End (FATE) in Glasgow.

90. One individual response suggested medical practitioners should be able to refuse to file pre-registration documents if they had a conscientious objection to assisted suicide.

FORMAL REQUEST PROCESS

Q5. Do you have any comment on the process proposed for the first and second formal requests (for example in terms of timings and safeguards)?

91. Opinions amongst the individuals who responded differed greatly on the formal request process:
    - one request should be sufficient
    - there should be more flexibility for the patient on the timing of requests
    - doctors would be required to establish that qualifying conditions have been met – they have neither the time or expertise to do this
    - by having two witnesses at the pre-registration stage but not at either of the formal requests means that the steps with the most gravity go unwitnessed
    - it would be an onerous process for a very sick person – it is unclear who would manage the process for them (i.e. facilitator, GP)
    - the timing aspect is too long drawn out
    - the time between formal requests could mean the patient's condition deteriorates rapidly, leaving them unable to sign the second request and suffering intolerable pain
    - the medical element should be removed from the 2nd request (a non-medical panel is suggested)
    - a verbal, rather than written, request (with a credible witness) should be allowed.

92. The organisations which responded to this question also had varied views about the formal request process. Eleven organisations had substantial concerns, while nine were neutral but expressed some view on changing the process. Two organisations were content with the process as described in the consultation paper.

Role of doctors

93. Some organisations raised issues regarding the ability of doctors to assess eligibility. MND Scotland (17) explained that motor neurone disease was a relatively rare condition which GPs may only encounter once or twice during their careers. The organisation advised that assessment would be particularly difficult if the doctor had not had a great deal of contact with the requesting person. There would be a similar issue with the requirement for assessment and verification by a second doctor. The case for further clarity on this issue was also made by the Prince & Princess of Wales Hospice (45) as different expertise was required for assessment of individual conditions, e.g. oncology versus neurology patients. The Royal College of Physicians of Edinburgh (25) stated that doctors involved should be fully trained in disease prognosis and the range of palliative care available, as should the second doctor.

94. In order to assist doctors making the assessment, the Scottish Partnership for Palliative Care (SPPC) (39) believed guidance should be provided to health professionals on the standards of diligence required when assessing eligibility. Consideration should be given as to whether clinicians need any particular skills, expertise or knowledge. The SPPC shared MND Scotland's view that it was more difficult to assess a request if a doctor had no prior knowledge of the person and pointed out the Bill did not require a practitioner to have prior knowledge of the person and their social or family circumstances.

95. In terms of process and knowledge of the person requesting assistance, Stirling & Clackmannanshire Shared Services (26) and the Royal College of General Practitioners Scotland (28) were unclear as to whether the doctor would have to be the individual's known GP, or any doctor, as well as who the second doctor would be and whether he/she would be based in the same practice.

96. Both the Methodist Church in Scotland (31) and the Catholic Parliamentary Office (31) sought assurances that the medical profession would be protected from coercion to become involved with the process and cited the precedent of moral drift which happened in relation to implementation of abortion legislation. In this respect, the Royal College of General Practitioners Scotland (28) suggested there might need to be a register of pro-assistance doctors, and that this would be especially important if all the doctors in the person's practice objected. Friends at the End (55) believed the individual's own doctor should be required, not expected, to refer to another doctor (this should also apply to pharmacists) and, in addition, the second doctor should have been qualified for more than ten years. Community Pharmacy Scotland (52) highlighted potential issues around finding two doctors in remote or island communities.

1st request

97. St Andrew's Hospice (32) was concerned that formal requests did not require witnesses.

98. Together for Short Lives (33) was concerned there was no psychiatric evaluation required, unlike in the previous bill. It advised that a simple legal test of incapacity is insufficient for adolescents. An individual may request assisted suicide because they feel like a burden to their family, and this type of pressure would not be apparent under the legislation. Simply having two doctors of unspecified training or experience was a weak safeguard. The organisation listed particular reservations about the removal of psychiatric assessments for young people:

    - It needs to be established there is no psychopathology, coercion or lack of voluntariness (one of the key demands of consent and therefore autonomy)
    - The support of a Child and Adolescent Mental Health specialist is mandatory in the care of 16-18 yr olds requesting suicide (assisted or otherwise) until depression is excluded. Under NICE guidelines, diagnosis and management of depression cannot be done alone
    - If a young person refuses life-sustaining treatment that others regard in their best interests, there is a rigorous examination of all the elements that are involved in the refusal. There should be parity where a person requests assistance to die i.e. a rigorous examination of the circumstances.

99. Also in relation to assessment, the Prince & Princess of Wales Hospice (45) said that, in order to fully assess a person for subtle psychological or psychiatric issues, a number of sessions would be needed which would be extremely time consuming - especially if the person conducting it had no prior knowledge of the patient.

Time between 1st and 2nd request

100. The Royal College of Physicians of Edinburgh (25) considered that the 14 day interval between requests struck the right balance. Dignity in Dying (5) also supported the requirement for a 1st and 2nd formal request; however it wanted alternatives to

assisted dying to be discussed before the process was started to allow parties to consider palliative and supportive care options. The Royal Pharmaceutical Society Scotland (9) was also supportive of the process of two formal requests and an interval between them, but considered it should be a pre-requisite that counselling and advice is provided between the 1st and 2nd request.

101. Inclusion Scotland (22) was however clear that 14 days was not sufficient time in which to explore the alternatives. This view was shared by the Scottish Partnership for Palliative Care (39) which explained that palliative care practitioners would have to balance the needs of other seriously ill patients against those who wished an assisted suicide. Strathcarron Hospice (44) expanded on this point, saying that responding to a patient in a particular time window would skew provision of their overall care and place staff under considerable pressure; staff might also experience strong feelings of guilt if, after offering care, the patient chose to commit suicide. The Prince & Princess of Wales Hospice (45) said that any expectation of a rapid response to address assisted suicide requests while patients with higher needs were sidelined was unacceptable.

102. Dignitas (10) also did not agree with the proposed waiting time of 14 days because for a terminal cancer patient suffering from extreme pain 14 days was a very long time. Dignitas (10) proposed implementing a one-formal approach request along the lines of the 'Swiss model' involving one medical doctor, whom the patient could contact and access again as soon as a 'provisional green light' for assisted suicide was given.

2nd request

103. Dignity in Dying (5) was concerned that, where the 2nd formal request was not made within 14 days, the process would start from the beginning. It considered this system would have the effect of potentially making the person feel pressurized into proceeding with a request for assistance. It was also felt that, if the person had to start the process again, this could cause them an additional emotional burden.

DETERIORATION OF CAPACITY

Q6. Do you think a time-limit of 28 days (or some other period) is an appropriate safeguard against any deterioration of capacity?

104. 91 individual respondents and three organisations (Royal Pharmaceutical Society Scotland (9), Community Pharmacy Scotland (52) and Friends at the End (55)) agreed 28 days was a suitable time-limit.

105. There was a range of opinions among other individual respondents who provided a variety of suggestions as to the appropriate time-limit. While some thought the time-limit should be extended to 42 days, six weeks, two or three months or even to six months, others had a preference for a reduction to 21 days, seven days or 48 hours.

106. Several individuals felt it should be determined by the patient in order to reflect the patient's situation, as it was impossible to determine the pace of deterioration in some terminal illnesses. One individual (67) raised concerns that the process would be halted where there was doubt about capacity arising after the 2nd request and that this seemed to penalise the patient.

107. Eleven organisations including the Humanist Society of Scotland (8) and SPUC Scotland (23) considered the specification of a time-limit an arbitrary method of ensuring a patient had capacity. MND Scotland (17) illustrated this in relation to physical capacity, saying that motor neurone disease was such a rapidly progressing condition that within a 28 day period a person may lose the ability to self-administer the lethal medication.

108. Dignity in Dying (5) suggested an alternative way to ensure capacity when taking the medication was an on-the-spot capacity assessment[1]. In support of this approach Dignity in Dying made reference to the Oregon figures where only around 60% take the prescription dispensed. In Oregon an additional waiting period of 48 hrs is required where there is a second request to receive the medication.

109. Another concern expressed by Dignitas (10) was that imposing a deadline tempted the person to go ahead with the assisted suicide knowing otherwise they would be back to the beginning of the process. It believed sufferers were actually looking for the comfort of having an 'emergency exit' and – that only 14% take up the option. Dignitas suggested that by changing the assessment of capacity to ensure continuous assessment of capacity you could remove this hurdle. The view that a time-limit may result in someone feeling pressured to take the medication before the deadline was shared by the Royal College of Physicians of Edinburgh (25). It suggested carrying out a capacity assessment 24 hours before an assisted death if there was a concern about capacity, as capacity can alter substantially in less than 28 days and sometimes changes can be temporary. Strathcarron Hospice (44) pointed out that it was difficult to predict deterioration of capacity in both malignant and progressive conditions, adding that metabolic problems and infections may cause a temporary change in capacity.

FACILITATOR ROLE

Q7. Do you agree that the presence of a disinterested, trained facilitator should be required at the time the medication is taken? Do you have any comments on the system outlined for training and licensing facilitators?

110. One hundred and forty-six respondents and nine organisations agreed with the requirement for the presence of a disinterested trained facilitator. The Humanist Society Scotland (8), Dignity in Dying (5) and Friends at the End (FATE) (55) agreed with the proposed role of the facilitator. FATE deemed this approach, based on the Swiss model, **to be both professional and compassionate. The Humanist Society Scotland (8) was inte**rested in further exploration of the proposed role and highlighted its potential interest in being a host organisation.

111. Dignitas (10) also supported the presence of a trained and licensed facilitator. It stated while the role outlined was very similar to the 'Swiss model', they usually had two facilitators present, one able to take care of the individual concerned and a second to

[1] see Consultation organisation response 5, for original footnote (p344 of Commission on Assisted Dying report 2011)

attend to the welfare of family and friends. Dignitas explained it was also better to have two people present in the interest of safety, especially if filming was required.

112. Stirling & Clackmannanshire Shared Services (26) agreed with the proposed role, but sought clarification as to whether local authorities would have any delegated power to accept applications from voluntary organisations.

113. Although the Crown Terrace Baptist Church, Aberdeen (51) recognised the need for an impartial facilitator not connected to the person, it considered there should be a requirement for a supporter to be chosen by the individual.

114. A large proportion of those who agreed with the facilitator role mentioned the importance of training.

115. Fifty-seven individual respondents and eight organisations objected to the role of facilitator.

116. SPUC Scotland (23) believed the role of the facilitator was unworkable. The organisation asked how a 'disinterested' person could be so intimately involved with the person to ensure that the 'medication' was taken only in their presence and under their guidance. Another issue which concerned some was the vetting of potential facilitators. The Methodist Church in Scotland (31) questioned how a trained facilitator could be 'disinterested'. The applicant may have come to the role for a variety of reasons (commercial, sense of calling, curiosity) and some might not be for the best of reasons. "It would take a leap of faith to believe that undesirable people would not be drawn to the role as a 'disinterested trained killer'". Seven individuals were also unsure about vetting; they believed there would need to be a robust selection process to avoid any of the anxieties caused by the Dr Harold Shipman case.

117. Several respondents also expressed concern about the term 'disinterested' and thought anyone involved in the process could not be described as 'disinterested'. The term "objective and independent" was proposed as an alternative.

118. Eight organisations did not share an opinion on the advantages or otherwise of having a licensed facilitator but provided comments on the facilitation role more generally.

119. One of the primary areas raised in this respect was training. The Royal Pharmaceutical Society Scotland (9) said that training should be multidisciplinary in nature to ensure a consistent approach and also be mandatory for anyone who wished to participate in an assisted suicide procedure. The Royal College of Physicians of Edinburgh stated a database of doctors, pharmacists and facilitators, who had opted in (rather than out) to that role, and had completed the training, would allow people a choice of whom they wished to be involved in this very personal experience when discussing practical arrangements with their doctor. Careful consideration would have to be given to when and by whom the database was accessed in order to protect those individuals whose names it contained, and it should not be in the public domain.

120. Another aspect which required further consideration was the facilitator's role when there were complications with the assisted suicide (e.g. person changes their mind

during the process or medication fails to be effective). Both the Royal College of Physicians of Edinburgh (25) and the Royal College of General Practitioners Scotland (28) had questions about what the procedure would be – for example, at what stage would the trained facilitator be expected to intervene if the medication was clearly failing? St Andrew's Hospice (32) considered that training for facilitators should be extensive and include dealing with complications arising during the assisted suicide and the management of complex emotion for the facilitator and family. The Scottish Partnership for Palliative Care (SPPC) (39) shared this view and stated that training should be given to facilitators to deal with conflicts within families, i.e. suggestions of undue influence etc. SPPC also asked for clarification as to the role of health professionals if medical complications arose and what the duty of care was in these circumstances.

121. The division of roles between health professionals and others involved in the process was another area which arose for clarification. The view of the Royal College of General Practitioners Scotland (28) was that administrative roles should be carried out by a non-clinician and should be a paid role rather than a voluntary role as this would allow for appropriate safeguards on a contractual basis. Licensed facilitators come under government jurisdiction, as doctors were under the General Medical Council (GMC). The Catholic Parliamentary Office (34) was clear that acting as a licensed facilitator was incompatible with registration as a medical practitioner. It made the point that, in countries which practiced capital punishment by lethal injection, the injection was not administered by a medical professional. It suggested the Scottish Government must maintain a register given the seriousness of the role and because facilitators would have immunity from prosecution for the offences of assisting suicide and the possession of lethal drugs.

122. South Lanarkshire Council (53) explored the boundaries of the role of facilitator in assisting a suicide. It considered that the facilitator (although not permitted to administer the medication) could provide a prompt to ensure it was taken correctly. The Council suggested, however, that there may be a narrow line between a prompt and what might be seen as direct assistance.

123. The Council's other concern was in relation to the storage of the lethal medication once dispensed from the pharmacy. It suggested there needed to be secure storage and provision for unused drugs to be returned to reduce the risk to others because the person might lose capacity, or change their mind, which could mean lethal drugs within community settings.

124. Other general comments which arose in relation to the role of the facilitator:
- he/she would need to build up a relationship with patient
- there may be difficulty recruiting people to train in this role – concerns about the perception of facilitators by the public
- concern about the negative effect on the facilitator's own well-being, and a suggestion that he/she would need access to support services

DOCUMENTATION AND EVIDENCE

Q8. What sort of documentation and evidence is likely to be required? In particular, how important is it that the process is filmed?

Filming

125. Sixty-one individual respondents and 16 organisations were against filming the process of assisted suicide to provide evidence. The main reasons were that it was considered to be an intrusion of privacy, indecent, distasteful or morbid. The other primary reason was that filming would not show any coercion or encouragement that might be given at other times in the process.

126. BMA Scotland (3), the Royal Pharmaceutical Society Scotland (9) and People First (Scotland) (38) advised that filming raised potential difficulties regarding the security of the sensitive data and the use of the film afterwards, while maintaining the dignity of the people involved. The protection of the dignity of the individual should be paramount and if sufficient legal protection for those involved could be achieved without filming then this would be preferable. The Church of Scotland (21) was also concerned about security of the film and how easy it would be to 'leak' a film on to the internet.

127. Another disadvantage raised in relation to filming concerned what would happen if consent to filming was withheld. MND Scotland (17) asked whether, in these circumstances, the process would have to be stopped.

128. Fifty-three individual respondents and two organisations (Stirling and Clackmannanshire Shared Services (26) and Friends at the End (55)) agreed with filming as it was seen as an important safeguard for all those involved.

129. While 21 individuals and two organisations (Dignitas (10) Friends at the End (55)) felt that filming should be optional and only if agreed to by the patient and/or family. Dignitas (10) highlighted it was important to retain the personal dignity of the individual involved and therefore filming should always be on a voluntary basis and never mandatory.

130. Reasons given in preference of filming (whether mandatory or optional) were:

- it would be a safeguard for patient and the facilitator;
- it is vital to record the place, time and date; and
- it would be useful in the event that disgruntled relatives raised legal issues.

131. Although filming was seen by some to have advantages, a number of individuals stated they did not want the film to be kept indefinitely, with one suggesting this should be provided for in legislation. SPUC Scotland (23) questioned why the proposal did not say that the film must be provided to the police, and only that it could be provided.

132. Nine organisations did not express a view on the advantages or disadvantages of filming or were neutral about the use filming to provide evidence. Dignity in Dying (5) considered there should be further exploration of the pros and cons of filming. Its submission explained that filming is used in Switzerland because assisted suicide had not been specifically legislated for and regulated.

Other documentation or evidence

133. Both individuals and organisations considered documentation needed to be robust enough to show that the law had been complied with at every stage in the process. The Scottish Partnership for Palliative Care (39) expanded on this by suggesting the reporting regime should be based on formal documentation of the whole process to generate a clear data set to allow for monitoring, scrutiny, audit, regulation and research into a controversial, evolving area of public policy.

134. The Royal Pharmaceutical Society Scotland (9) supported nationally agreed paperwork with standardised protocols and procedures - in particular, information informing pharmacists of previous interventions. The Society also considered paperwork confirming the legal status of the request would need to be available to the pharmacist before a lethal prescription was issued. In relation to dispensing the lethal medication, Community Pharmacy Scotland (52) also suggested that pharmacists asked to dispense medication for assisted suicide should be provided with clear proof that the prescriber intended the supply of medicine for that use. This documentation would enable pharmacists to choose whether to supply the medicine or refer the patient to another pharmacy. Health boards should be required to prepare a list of pharmacy contractors prepared to supply the medicines to assist the quick referral of a patient to a supportive pharmacy.

135. Dignitas (10) listed the documentation required in the Swiss model and suggested that this documentation nullified the need for filming. These documents were available to the police and coroner who investigated each assisted suicide. The documents included the Dignitas living will, a copy of the formal request for an accompanied suicide, a 'Voluntary death declaration', a Power of Attorney, and a 'disposition of personal belongings'.

Certification of death

136. Both Dignity in Dying (5) and the Royal College of Physicians of Edinburgh (25) highlighted that processes for pronouncing life extinct or for certification of death needed to be addressed. It was unclear to the Royal College of Physicians of Edinburgh whether the death was to be recorded as an unnatural death which required the police and/or Procurator Fiscal to be involved. Dignity in Dying (5) suggested that a doctor should be required to certify death and notify the national monitoring commission responsible for regulating the practice of the law. Information should be provided on what is to be contained in the death certificate. This would enable an annual report of deaths and reasons for requesting assistance etc. to be produced.

137. A toxicology report appeared to the Catholic Parliamentary Office (34) to be necessary to confirm the cause of death and as such it considered this should be part of any recording of the death. The organisation pointed to the lessons learned from the loss of evidence due to cremation in relation to the proceedings against Dr Harold Shipman and this should be borne in mind when devising adequate means of record keeping.

Witnesses

138. Another area which arose in relation to providing the necessary evidence was the use of witnesses. Some considered filming a poor second to the presence of a witness. An individual expressed concern that the proposed bill made no requirement for

witnesses to the death, other than the facilitator, and that (even if the process was filmed) this left too much open to potential mistakes, errors of judgement, and perhaps even coercion.

FINANCIAL IMPLICATIONS

Q9. What is your assessment of the likely financial implications of the proposed Bill to your organisation? Do you consider that any other financial implications could arise?

139. A few general themes arose in response to this question. Some responses highlighted that it was not clear from the consultation paper how assisted suicide was to be funded and therefore there was some confusion about whether the provision of assisted suicide was to be embedded in the NHS.

140. Another general theme which arose was concern that provision of funding for assisted suicide would divert funds and resources away from supporting the provision of palliative care. Alzheimers Scotland (19) supported this view although its concern was in relation to any unintended adverse effect on investment in dementia care services.

141. The balance of views was reflected that the implementation of the proposed Bill would result in some financial impact.

Costs to the Scottish Government

Potential costs identified

142. Stirling & Clackmannanshire Shared Services (SCSS) (26) considered there would be costs for the Scottish Government in producing literature and guidance both for the public and medical professionals. SCSS sought clarification on whether local authorities would be expected to disseminate information; it suggested that they would need guidance on how to direct queries and should have no role in producing guidance. The Scottish Council on Human Bioethics (7) cautioned that any government financial support would undermine its campaign to reduce suicides. It also suggested that funding of assisted suicide would undermine the Scottish Government's position that all human life has inherent human dignity which was vital for a civilised society to exist. Strathcarron Hospice (44) questioned whether assisted suicide was something the taxpayer would reasonably wish to fund.

Costs to the National Health Service (NHS)

Potential costs identified

143. The Royal Pharmaceutical Society Scotland (9) did not envisage any major financial implications for the pharmacy profession if fully implemented within the NHS. Its preference was for NHS Education for Scotland to deliver facilitator training rather than a voluntary organisation. NHS National Services Scotland (11) identified a number of changes that would be needed to a number of IT systems to support the process of assisted suicide. In particular it identified changes to two GP IT systems (EMIS and InPS Vision), the GP out-of-hours system Adastra and others such as the electronic

Palliative Care Summary (ePCS) and the Emergency Care Summary (ECS) and the ePharmacy systems and this will have financial implications for NHS Scotland.

144. The Royal College of Physicians of Edinburgh (25) also believed there would be financial implications for the National Health Service, for example, in funding GP and consultant time to include time for training, performing assessments, discussions with patients, audit and record keeping. The organisation sought clarity as to whether the process was to be part of GMS or dealt with separately. The Royal College of Physicians of Edinburgh further highlighted financial implications might arise from indemnity issues for all health professionals and licensed facilitators.

145. Community Pharmacy Scotland (52) identified costs to the NHS in relation to the reimbursement of medicines provided for assisted suicide, although it was unsure whether the supply of medicines was to be provided on a private basis, in which case the costs would fall on the individual.

Costs to the Crown Office and the police

146. Community Pharmacy Scotland (52) suggested that further consideration should be given to any associated costs in relation to the police and Procurators Fiscal.

Costs to organisations (including voluntary organisations)

No costs identified

147. Eight individual respondents thought there would be no direct financial impact on organisation and four organisations thought there would be no direct financial impact on their organisations - The Humanist Society of Scotland (HSS) (8), Friends at the End (55), the Church of Scotland (21) and Dignitas (10). The Church of Scotland (21) however pointed out that caring for the most vulnerable in our society would always be costly. Dignitas explained why there would be no direct impact on it, since it charged people only to cover the cost of providing a service to them. The proposed Bill would mean fewer people using its service, but correspondingly lower costs, and hence no overall impact on its budget.

Potential costs identified

148. MND Scotland (17) thought it would need to carry out awareness raising and training of staff to be able to respond to questions around the process. The Humanist Society Scotland (HSS) (8) advised that, should HSS pursue its interest in hosting the facilitator role, there may be future cost implications but was not able to comment at this stage. As well as the costs identified to the NHS, St Andrew's Hospice (32) considered the extensive requirement for education and training for those health care staff involved would be an additional cost to independent health care providers and was concerned who would bear the cost. The Scottish Partnership for Palliative Care (39) also highlighted training as a significant cost for social care staff who worked within specialist palliative care, particularly where training budgets were under pressure.

149. Strathcarron Hospice (44) considered that the legislation could put significant pressure on their bereavement services. This was because there was no requirement for the person to discuss assisted suicide openly with their relatives and therefore it was anticipated there would be significant repercussions for bereavement services. The

Hospice further explained that people who experienced sudden bereavement could have particular difficulties coping with their loss.

Cost relating to licensed facilitators

150. The consultation paper envisaged the role of facilitator being carried out by voluntary organisations. A number of responses indicated there were some uncertainties about the organisational framework for licensed facilitators and therefore related funding issues.

151. Both the Royal College of General Practitioners (28) and Community Pharmacy Scotland (52) asked if 'licensed facilitators' would be a paid position and if so who would be responsible for funding.

152. Certain functions associated with the provision of licensed facilitators were identified as having a cost. Training of facilitators was acknowledged to be the central cost. The cost of training was raised by Royal College of Physicians of Edinburgh (25), Royal College of General Practitioners (28), Strathcarron Hospice (44) as well as some individuals (47) and (50). Also highlighted as incurring a cost was the vetting of facilitators. Community Pharmacy Scotland (52) suggested the role of facilitator was likely to require Protection of Vulnerable Groups (PVG) clearance which came at a cost and asked whether this would be borne by the Scottish Government or the trained facilitator. Costs were also identified in relation to any licensing, monitoring and regulation regime adopted in respect of facilitators.

153. Dignitas (10) agreed with the member's approach on vetting and licensing, but suggested that facilitators should have access (free of charge) to debriefing and psychological supervision, something Dignitas offered to all its employees.

Cost to the individual

154. Depending on how the process of assisted suicide was funded there may be costs to the individual. The Salvation Army (43) suggested that costs placed on the individual in seeking assistance could create a two-tier system where only the wealthier chose assisted suicide and the poor continued with the current situation. One respondent (6) suggested that if charges were to be made to individuals these should be capped to make it affordable to all.

155. The other main issue which arose in relation to individuals requesting assisted suicide was the effect on life insurance policies, as there was no discussion of financial protection for dependents and minors in the consultation paper. St Columba's Hospice (16), MND Scotland (17), SPUC Scotland (23) and the Royal College of Physicians of Edinburgh (25) asked if there would be an issue around insurance pay-outs to policy beneficiaries. SPUC Scotland (23) advised that, typically, life insurance would not pay out in the circumstances of suicide and directed the member to similar legislation proposed elsewhere which specified insurance must be paid out.

156. St Andrew's Hospice (32) believed research should be conducted into the effects of assisted suicide on the families, carers and professionals involved. Any long-term effects could potentially have an impact on the individual's ability to work and their reliance on health and welfare services.

Potential savings

157. A number of respondents highlighted ways in which the proposed Bill could bring about savings for the public purse. One respondent (23) commented that the proposed legislation would have positive financial implications by leading to savings on highly expensive palliative care.

158. In terms of where these savings could arise, the Scottish Partnership for Palliative Care (39) indicated financial savings could accrue to the NHS and social work services. There could also be savings from welfare/social security/pension budgets.

EQUALITY ISSUES

Q10. Is the proposed Bill likely to have any substantial positive or negative implications for equality? If it is likely to have a substantial negative implication, how might this be minimised or avoided?

No implications

159. Thirty-three individual respondents and two organisations (Stirling and Clackmannanshire Shared Services and Community Pharmacy Scotland) felt the proposed bill did not present any implications for equality. The Humanist Society of Scotland believed the focus of the proposed Bill on autonomy of the individual negated any substantial negative implications for equality, while Friends at the End stated there was no evidence to support the proposed bill would result in those disabled being less valued than anyone else.

160. One individual (64) said he did not think that the proposed bill would lead to the demise of society in the way that some suggested: “If Scotland is to be brave – it must first be bold”. Another respondent (50) saw “this proposed bill as fair and equitable. It puts the individual and their choice at the centre of the proposal”.

Gender

161. With regard to gender, one respondent (30) considered it possible that, given the statistics relating to life expectancy and demographics, there would be a bias towards women. It was the respondent’s view that the conscious decision to end life under the terms outlined in the proposed Bill rendered gender irrelevant.

Disability

162. In relation to disability, an individual (7) stated “I disagree that the concept of a competent individual wishing to choose the timing and circumstances of their death in a terminal situation is linked to saying that a disabled life is not worth living”.

Negative implications

163. Twenty-one organisations (including hospices, religious organisations and charity groups) had concerns that the proposal would have a negative impact on equality.

Value of life

164. One of the main reasons was related to the value of life. According to the Scottish Council of Bioethics (7) for society, "to accept assisted suicide means that it would have to also accept that some lives are unworthy of life which completely undermines any notion of equality between individuals in society." Suffering and dying persons would begin to see that they had no worth to society and therefore would have a duty to die quickly." The Catholic Parliamentary Office saw a negative impact on the understanding of equality by removing the protections of internationally agreed human rights. It considered the proposed Bill would breach article 1 of ECHR, article 1 of the Universal Declaration of Human Rights and article 6 of the International Covenant on Civil and Political Rights.

Eligibility criteria

165. Another concern was the eligibility criteria. Some respondents considered those who did not meet the eligibility criteria were discriminated against, for example those with a non-progressive illness, the under 16s, or those who lack capacity e.g. those suffering with Alzheimers. MND Scotland (17) stated that potentially some motor neurone disease sufferers would be discriminated against because they couldn't self-administer the lethal medication. This view was shared by St Andrew's Hospice (32) and Scottish Partnership for Palliative Care (39).

166. Dignitas (10) believed that limiting access to assisted suicide to certain individuals automatically led to discrimination against those excluded. Those excluded were exposed to the high risks associated with 'clandestine' suicide attempts via inadequate means with all the dire consequences for them, their loved ones and third parties such as train drivers, rescuers, etc. The proposed bill set an eligibility criterion on the person to have a 'terminal illness or a terminal condition'. Dignitas believed from both a humanitarian and human rights approach, limiting access to just the terminally ill was discrimination and not justifiable. An individual (24), Tony Nicklinson who suffered from locked-in syndrome, suggested discrimination could be avoided by making assisted dying available to every mentally competent adult.

Ethnic and religious minorities

167. The Catholic Medical Association (50) raised an issue regarding the impact of the proposal on ethnic and religious minorities. It referred to experience in Australia's Northern Territories where Aborigines avoided health care because physician assisted suicide was permitted. It believed the health care profession should reflect the diversity of the population it served. It was predictable that professionals drawn from significant cultural, religious and ethnic minorities would feel compelled to participate or they would be effectively excluded from working in these areas as a result of the proposed legislation. Together for Short Lives (33) felt it was inevitable that any Bill would result in a disparity between white British and other racial groups. Individuals would not access assisted suicide unless they felt able to discuss death. This was much more likely among white British individuals than among ethnic minorities, for many of whom death was a taboo subject that could not be discussed.

Gender

168. In relation to gender, SPUC Scotland (23) advised that in other settings where assisted suicide and/or euthanasia were legal more women than men end their lives. Although the reasons weren't clear it felt it was likely that a large number of women were in the caring profession and therefore they had a better knowledge of the effort

required to look after someone who was old, frail disabled or suffering in some way and it was likely they could feel themselves to be more of a burden for those who cared for them.

Disability

169. Inclusion Scotland (22) considered there would be a substantial impact on the equality of disabled people. It believed many were already disadvantaged by their socio-economic status because of which they had limited access to good quality end-of-life care and palliative care. Inclusion Scotland believed the only way to minimise these effects was to withdraw the proposed bill. One response (6) suggested individuals with "learning difficulties" might be less able to understand and use the process. Concern was also expressed by People First Scotland (38) that the proposed Bill would lead to more negative discriminatory attitudes towards people with disabilities and terminal conditions. Assisted suicide would be seen as a substitute for individualised, well-funded care.

Positive implications

170. Five individual respondents and one organisation (Dying in Dignity (5)) believed the proposal would have positive implications, particularly because individuals who do not have the ability to pay to travel abroad would be able to access assisted suicide in Scotland.

SECTION 4: MEMBER'S COMMENTARY

Margo MacDonald MSP has provided the following commentary on the results of the consultation, as summarised in sections 1-3 above.

My sincere thanks are due to the Non-Government Bills Unit (NGBU) for the assistance given by it when the responses to my consultation had to be analysed. Given the substantial response, the NGBU clerks are to be commended for the clarity of their observations and conclusions. I'm also most grateful for the advice and encouragement I've received from individual members of the medical and nursing professions, prominent amongst whom has been Dr Libby Wilson.

I must also record my great appreciation of, and thanks for, the work done in the collation and publication of this document by my Office Manager, Peter Warren. His contribution to the entire process has been immense and essential.

The debate has moved on since I introduced my previous Bill in 2010. The recent sad death of Tony Nicklinson, who suffered Locked-in Syndrome in its extreme form, but whose attempt to end his life with help that was legally given was denied by the English courts, brought the issue into the spotlight. Recently Anna Soubry MP, under-secretary at the Department of Health in London made encouragingly positive remarks about the right of the terminally ill to decide on when they should die. This was followed by comments from the new Minister of State Norman Lamb on the same matter. Hopefully this indicates a more realistic attitude on the part of the UK Government that more accurately reflects public opinion.

With reference to the replies to my consultation, the raw data would appear to be quite opposed to the evidence of opinion polling in producing a figure of 64% of respondents against the proposal. Under closer analysis, a considerable number of these responses used identical language to voice their opposition. The root of the opposition appears to lie in the religious beliefs of the respondents. That being the case, though I admire their commitment and support their right to organise opposition, theirs is no more compelling than any other opposition simply because it is faith-based.

Successful legislation requires twin supports of accessibility and robustness. Good legislation is accessible and clear in its aims. Equally it should be robust enough to withstand any challenges as well as guarantee the rights of those who wish to abstain from using it.

A successful consultation should be able to achieve two aims: it will allow the MSP in charge to test public reaction to ideas under consideration that may, or may not, be included in the eventual Bill's provisions, whilst setting out the general aims of the Bill. Of those who responded directly to the questions in the consultation, 100 judged the eligibility criteria to be appropriate, 11 thought them otherwise.

The above questions were important as many people see "eligibility" as being the most dangerous part of my proposals. Unfortunately, some people and organisations that defend the rights of disabled, vulnerable and old people opposed my previous Bill because they were nervous as to how its provisions would affect such people. As in the previous consultation, responses from this group are emotional rather than rational and opinion rather than proven fact.

The new bill is likely to be different in a number of details, and as stated above the consultation aimed to test support for the new approach with the aim of producing a fair, equitable and sound piece of legislation. The organised opposition has not developed its analysis: the fear is that Assisted Death, undertaken only at the request of the person concerned, will put at risk vulnerable people. Experience from jurisdictions where Assisted Death has been legal for some years contradicts this fear comprehensively

As the MSP in charge of the Bill, I see its functions as being compatible with other human rights exercised by the individual as regards life choices. The Supreme Court of British Columbia would seem to be in agreement with this principle. In June, the Court ordered the Federal Government of Canada to bring forward legislation to permit assisted suicide within a year. (Carter vs. Canada (Attorney General) 20012 BCSC 886).

One element of the Bill which has been useful to test is that of the eligibility requirements. I have been determined to get the balance right in terms of reassuring the Bill's opponents that there are robust defences against abuse of the Bill, and an accessible but testing pathway for anyone suffering from a terminal illness or condition who indicates a desire to end a life that has become intolerable. The fine judgement comes from the difference between evaluating the whole person and not just the condition from which they suffer.

Another change to the legislative package under preparation following the consultation is my decision not to incorporate filming the very end of life at an assisted death. Filming this most intimate and personal of moments was rejected by many consultees as a means of ensuring the legislation was not abused. I trust in the robustness of the registration and training of licensed facilitators, together with the codes of practice that will be supplied by the various professional bodies and the requirement for the death to be investigated by the Procurator Fiscal. In my view, these combine to make filming redundant.

My proposal depends on three key factors:

- Agreement by doctors to accept patients' pre-registration and a later stage expedite a qualified patient's right to end his or her life
- Agreement of pharmacists to dispense lethal prescriptions
- Identification and training of facilitators.

During the process of building this Bill, the Royal College of GPs has made known its "neutrality", thus joining the stance taken by the Royal Pharmaceutical Society and Community Pharmacy Scotland. The last two have offered their assistance in the process of drafting the bill.

Invaluable assistance has already been given, with more promised as needed, from the Humanist Society Scotland. The Society understands the needs of the legislation as regards recruiting training and monitoring appropriate Facilitators. Humanists are already familiar with and practised in a range of life-style functions. The Society thinks a sufficient number of its members would become facilitators.

Annexe A

List of individual responses (numbered as received) to the Assisted Suicide (Scotland) Bill consultation

Number	Name
1	Guy Johnstone
2	Andrew Cross
3	John Thomas
4	Anon
5	Anon
6	Dr Hugh Wynne
7	Dr Stephen McCabe
8	Malcolm McDonald
9	Rev John Millar
10	Mrs Janet Candice-Wade
11	Mr David Flatman
12	Mr Ed Wade
13	Mrs Victoria Allan
14	Mr & Mrs Pearson
15	Anon
16	James MacDonald
17	Eleanor Steiner
18	Vivien Stewart
19	John Higgon
20	Graeme Wallace
21	Colin & Isobel McLauchlan
22	Gerald McGovern

Number	Name
23	Mr Robert Taylor
24	Tony Nicklinson
25	Miss Elizabeth Crombie
26	Anon
27	J Matthews
28	Janis Gair
29	Douglas Hall
30	Mr Bill Mitchell
31	Mr David Alford
32	Mr Mike Assenti
33	Mr Bob Smith
34	Mr & Mrs Sheriff
35	Mr T Clark
36	Stuart A. Hannah
37	Allan & Helen MacEachen
38	Mrs C McFarlane
39	Mrs A Mallon
40	Peter Neilson
41	Mrs C Geddes
42	Ms R Plevin
43	Jennifer & Bill Campbell
44	Neil Sharp

Number	Name
45	Pat Lines
46	Ulrike Rawson
47	Joan Lockhart
48	Carolyn MacDonald
49	Jean & Brian Pryde
50	Ewen Sutherland
51	Ronald Douglas
52	George Learnonth
53	Ken Cohran
54	Nick & Meg Stroud
55	Diane Griffiths
56	John Robbins
57	Peter Meikle
58	Dr Mary Bliss
59	Alan & Ann Brown
60	Geoff Lamb
61	Doreen Galbreath
62	Dolina Stephen
63	Bruce & Marjorie Borthwick
64	Garry Graham
65	David Lewis
66	Evelyn Higgins
67	Iain Kerr
68	Ernest Law
69	Dorothy McPhillimy
70	Mary Rocchiccioli

Number	Name
71	Dorothea Evans
72	Charles Holt
73	Paul Brownsey
74	Barbara Bielby
75	Dr Clive Preston
76	Anon
77	Jessamy Pears
78	Ian Smith
79	Moira Pfush
80	Carol G.
81	Ian Gow
82	Janet Inglis
83	Mrs Jones
84	George Wade
85	Michael Irwin
86	Mrs M McFarlane
87	Gillian Chipperfield
88	Judith Cantley
89	Mr Stuart Gamble
90	Mr Martin Norval
91	Iain & Hilary Stuart
92	Dr Ann Ralph
93	Teresa McNally
94	Malcolm Allan
95	Margaret Spiers
96	Chris Rackham

Number	Name
97	Jean Pinknev
98	Anon
99	William Cowie
100	Isabella Paterson
101	Ray Morris
102	Graham & Elizabeth Carson
103	Colin MacFadyen
104	Peter Stewart
105	Charles Warlow
106	Jim McRobert
107	Mr Martin
108	David Fairley
109	Raymond Stibbles
110	Graeme McKiggan
111	Catherine Joshi
112	Kenneth Matthews
113	Alan Dunnett
114	Mary Ainsworth
115	Richard Bingham
116	Jean Clark
117	William Morrison
118	John Lind
119	S W Shaw
120	Prof. Marie Fallon & Dr David Jeffrey
121	Robin Hassall

Number	Name
122	Dorothy Fox
123	Kirsty Williams
124	Ralph Green
125	Jeffrey Milne
126	Gerald Cunningham
127	Steve Hay
128	Steve Oliver
129	Graeme Harrison
130	Bert Rima
131	George Cook
132	David & Jeannette Ferguson
133	Carey Lunan
134	Feena Horne
135	Stuart Dunnett
136	Andy Moore
137	Montague Burkeman
138	Agnes Stevenson
139	Shirley Curle
140	Marie O'Donnell
141	Barbara-Anne Norval
142	Susan Bittker
143	Ronnie Brown
144	Rosemary Cameron
145	Lesley Ward
146	Derek Ross

Number	Name
147	Gordon Aitchison
148	Anon
149	Graham Keith
150	Gillian Stewart
151	Marilyn Jackson
152	Gordon Wylie
153	Alan Richardson
154	Ross Wright
155	Joan Chester
156	Tim Maguire
157	Harry Kielty
158	Jennyfer Malyon
159	Phil Olson
160	Isobel McLachlan
161	Mike McNaught-Davis
162	Malcolm Garden
163	Derrick MacAllister
164	Jack Mcfie
165	J Colin Herd
166	Jen Jackson
167	Joan Cook
168	Alan Macintosh
169	Jean Davies
170	Dr Harry Scrimgeour
171	Evelyn Higgins
172	Dermont O'Sullivan

Number	Name
173	Joyce Scott
174	Elizabeth Bennett
175	Anon
176	Mrs Lamont
177	Norah Scanlan
178	Dr A Pilkington
179	Donald Black
180	Sylvia Rebus
181	Anne Stewart
182	Margaret McLaren
183	June MacCormack
184	Leslie Steele
185	Charles McEwan
186	Elaine Naughton
187	David McLean
188	Peter & Mary Stewart
189	Norman Atterbury
190	Ian Pape
191	Helen Moss
192	Hugh Mathie
193	Lynn Shelley
194	George Rutter
195	Dorle Dieppe
196	Helen Armstrong
197	Dr Sarah Glendinning
198	Jill Hutchinson

Number	Name
199	Rod & Avril Sharp
200	Wulf Stratling
201	Stewart Goudie
202	James Morris
203	Diana Coonagh
204	R Sewell
205	Peter Thompson
206	Rev Joseph Collins
207	Helen Favells
208	Alexander
209	Dennis Pedley
210	Michael Brogden
211	J Harrold
212	Anon
213	Brian Jones
214	Ernie Butler
215	Stephen Clark
216	Pearl Liddle
217	D Trowsdale
218	Alan & Pauline Barrow
219	Patrick Fleming
220	John Birkin
221	John Allman
222	Terry Cooper
223	Dominic Love
224	Gail Collings

Number	Name
225	Matthias Moeller
226	Eileen Middlefell
227	Susan Palmer
228	Shirley Harrington
229	Gail Jones
230	Patricia Chapman
231	J D Bullen
232	Peter Vinall
233	Steffan Jenkins
234	Scott Alan Smith
235	Brian Cairns
236	Michael Shannon
237	Ester Drake
238	John & Elaine Charnley
239	Henry Speedie
240	John Hannah
241	Hamish Goldie Scott
242	Clare Griffith
243	Evina Campbell
244	Keith Horsfall
245	Padma Amiliwala
246	Sophia
247	Wendy Churchill
248	Steven Grant
249	Chris Mackie
250	David Mills

Number	Name
251	Dr J Gordon
252	A J Wilson
253	Ann Farmer
254	Peter Jenkins
255	Norman Duncan
256	Rev James Davidson
257	Ian Benson
258	Tony & Lindsay Leney
259	Jane Hunter
260	Christine Campbell
261	Gerrard Carruthers
262	Patrick Kearns
263	Anna Noel Roduner
264	Mark Thompson
265	Anon
266	Brian Box
267	Sandra Brown
268	Marie Toone
269	Fiona Bradshaw
270	Ade Oyinloye
271	Dr S & Mrs I Hutchinson
272	Frances Aldridge
273	Quintin Bradshaw
274	Peter Prideaux
275	David Buchan
276	Sheena Jack

Number	Name
277	Lesley Ward
278	Sister C O'Connell
279	Maude Donkers
280	Ebun Ediale
281	Maria Igoe
282	Chris Rogers
283	Margaret Halliday
284	John Deeney
285	Katherine Naylor
286	Mrs Anne Weir
287	Colin Baker
288	Dr Andrew Bathgate
289	Michael Brownhill
290	Elizabeth McDowall
291	Dominic Statham
292	Allan Murray
293	Pete Torrance
294	David Daniels
295	Kay & Bob Scott
296	Philip Aitchison
297	Peter Jones
298	Pauline Sharp
299	Keith Field
300	Lawrence Johnstone
301	Leigh Belcham
302	Norris Thompson

Number	Name
303	Richard Anderson
304	Roger Woods
305	Helena Nixon
306	Joan Short
307	Malcolm Wilson
308	Chaplain David
309	Rev David Melville
310	Gary McFarlane
311	Alison Davies
312	DR Manning
313	Grace Cameron
314	Laurene Ramage
315	Christine Smith
316	Alexander Wright
317	Christine Molano
318	Anastasia Seipman
319	David Randall
320	Paula Sargeant
321	John Gardiner
322	Brian MacDonald
323	Lorna Hanlon
324	Pauline Van der Vos
325	Margaret Carlaw
326	David Donnison
327	Mrs Higgins
328	Hugh Allan

Number	Name
329	Liz Nichols
330	Lucile McCrory
331	Norma Peacock
332	Frances Reynolds
333	Trevor Stammers
334	GFC Brydone
335	Rhonwen Waugh
336	Callum Hawthorne
337	Fiona Beveridge
338	Tricia Kiehlmann
339	Mervyn Bufton
340	Diana Desport
341	John McCormick
342	William Primrose
343	Annette Brydone
344	Sandra Campbell
345	Kirsty Robinson
346	Kathy Gray
347	Nia Ball
348	Helen Bruce
349	Maureen Hutchison
350	Desmond Herkes
351	Wilma Duncan
352	Peter Dutton
353	Barbara Peardon
354	Marian Hall

Number	Name
355	Lachlan McDowall
356	George Wislon
357	Melanie MacPherson
358	Alistair Easton
359	Elizabeth Swain
360	Trevor Stone
361	Jane Graham
362	Sally Mitchell
363	Lesley Helfer
364	Elizabeth Wight
365	Angela Heaney
366	Alison Laing
367	Keith Rowbory
368	John Walsh
369	Anon
370	Martin Gem
371	Maura Rae
372	Maureen Lanigan
373	Kathleen Taylor
374	Debra Storr
375	Stephen Palmstrom
376	Dr Chris Woodcock
377	Derek Watt
378	Shirley Prahms
379	Tom & Elspeth Morrow
380	Alex McGuire

Number	Name
381	Kerr Brown
382	Elma & Andrew Young
383	Moses Moloi
384	Patricia Lowry
385	David Stewart
386	Stewart Martin
387	Julia Cosgrove
388	Stephen Blatch
389	Jenny Farrant
390	Mrs J Holt
391	Peter Cordle
392	Brian Halliday
393	Lynn Murray
394	Randall Lawler
395	Vivien Sleight
396	Dr Bruce Cleminson
397	Joanne Purcell
398	Steve Chinn
399	Gerard McReavy
400	Dr A Gibb
401	Katie Vickers
402	George Chalmers
403	Michael Rollo
404	Jane King
405	Sarah Mackie
406	John Berry

Number	Name
407	Clive Copus
408	Michelle Weeks
409	A Fricker
410	Lee Bronze
411	Edicula George
412	Sue Hesselwood
413	Dr Mark Donaldson
414	Jenny Engel
415	Ken & Sue Hirst
416	Ronald Douglas
417	Mrs Wilson
418	Michael Whitehead
419	C Greenhall
420	Jim Barbour
421	Hilary Nicholson
422	Colin Swan
423	Alan Haggerty
424	Valerie Maloney
425	Eileen Adams
426	Anon
427	Pauline Cutts
428	Keith Frobisher
429	Jim Sandall
430	Elizabeth Adam
431	Angela Rigby Doble
432	Joan Djan

Number	Name
433	Tola Ositelu
434	Lesley Mathison
435	Julian Tewskesbury
436	Colin Hession
437	Robert Brockbank
438	Robert Chevli
439	Dr Fiona Underhill
440	Kemba Agard
441	Daniele Ciraulo
442	Ian Wilson
443	Gwen Staveley
444	Gillian Taylor
445	Donald White
446	Linda Meiklejohn
447	John Humphrey
448	Irene Faseyi
449	Marjorie Blake
450	Stephen Taylor
451	Michael Taylor
452	Martin Kilner
453	Ann Thomas
454	Steve Finney
455	Alan Bourne
456	Gosia Shannon
457	Tom Higgins
458	G Haydock

Number	Name
459	Sandy Meiklejohn
460	Neil McKay
461	Sr Andrea Fraile
462	Jonathon O'Riordan
463	Michael Dillon
464	Margaret Fitzpatrick
465	Alastair Strickland
466	Jane Macfie
467	Joe & Pat Joghee
468	Deirdrie O'Reilly
469	Karlis Prahms
470	Alistair Forman
471	Paul Ede
472	Adam Dysko
473	Susan McAleer
474	Lisa Fergusson
475	Ian McCormick
476	Anne Wood
477	Eva Stevens
478	Ms G Johnson
479	Rev Scott McKenna
480	Sharon & Gareth Morgan
481	Anna Bradshaw
482	David Fraser
483	Vicky Dixon
484	Mary Frances Dysko

Number	Name
485	Suselle Boffey
486	Ruth McAdam
487	Michael Roche
488	Agnes Henderson
489	Seumas Macfarlane
490	Simon Hettle
491	Ian Smith
492	Margaret Barton
493	Anon
494	J Scott
495	Aileen Baird
496	Michael Black
497	Nicole Kane
498	Steve Hewett
499	Pat Heppell
500	Ann Matin
501	Alan Guy
502	Michael Carey
503	Rita &David Hall
504	Stanley James Wilson
505	Vincent McGread
506	Ellen Quirk
507	David MacLeod
508	Frances Burniston
509	Dominic Beer
510	Alistair Brunton

Number	Name
511	Josephine Robinson
512	Peter Hall
513	Mike Ryan
514	Stephen Gallacher
515	Chrissie Wright
516	Violet Docherty
517	Anne Jabir
518	Alan Donald
519	Lorna Nunn
520	Maureen Closs
521	Kay Lane
522	Richard Jones
523	Emily Maudsley
524	Murdo & Mary MacLeod
525	Lucille McQuade
526	Norman MacLeod
527	Lorna Goldring
528	James McGoarty
529	Nancy Adams
530	Jacqueline Dalyrmple
531	Leslie Tritton
532	Liz Spruell
533	Joe Bradley
534	Larry Callary
535	Alastair Noble
536	Alison Duthie

Number	Name
537	Alina Armstrong
538	Doreen Trust
539	Robert Paterson
540	John Craddock
541	Marion MacLeod
542	Eric Descheemaeker
543	Josephine Cecil
544	Catherine Bellew
545	Jean Steven
546	Joseph Quinn
547	Deborah Poole
548	Nancy & John Wright
549	Francis Doherty
550	Agnes Murray
551	Mary Soares
552	Robin Aston
553	Maria Ann McDonald
554	David Henderson
555	Andrew Gill
556	Maryln & Paul Leak
557	Rita Sciallo
558	Sandra Black
559	Emma Ramano
560	Violet McCombe
561	Mr & Mrs N Driver
562	Julie Kennedy

Number	Name
563	Lydia Proudman
564	Alistair Mckenzie
565	J Marshall
566	Moira Kerr
567	Anna Tyminska
568	Graeme Templeton
569	Dorothy Templeton
570	Lydia & Morrison Dorward
571	Peter Heggarty
572	Isobel O'Donnell
573	Effie Alexander
574	Mark McGreehin
575	Rona Hunter
576	Margaret Biggs
577	Marjory Mackay
578	Alex McCluskie
579	Sarah Worth
580	John McKenna
581	Dr Dorothy McMurray
582	Edward McConnell
583	Tony Foreman
584	Peter Brawley
585	Alasdair Fyfe
586	John & Alison Sloan
587	Gerry McLaughlin
588	Hugh & Chrissie Wright

Number	Name
589	Richard Morrison
590	Jack Lavety
591	Ruth Greenhalgh
592	Adrian Gallacher
593	David Kennedy
594	Mary Grant
595	Jacqueline Smith
596	Dr Walter McGinty
597	Denise Docherty
598	Nicola Lynas
599	Philip Anderson
600	Stella Money
601	Kirsty Scott
602	Jim & Moira McIntyre
603	Ron Scurfield
604	Jill Scurfield
605	Noel Slevin
606	David Charles
607	Martin Cameron
608	Euan Dodds
609	Joe Lee
610	Andrew Robertson
611	Annemarie Boyd
612	Cameron McLarty
613	Judith Frampton
614	Bayne Shaw

Number	Name
615	Richard Aspen
616	Stephen & Rosalind Malins
617	David Bell
618	Margaret Pattinson
619	Margaret Hunt
620	Daniel Muir
621	Terry Cockerell
622	Pauline Shirley
623	David Shirley
624	Anthony Fraser
625	Alan Johnston
626	Ishbel Mair
627	Clive Eakins
628	J Lisle
629	Eric MacKay
630	Catriona McLean
631	Michael & Leonar Hartley
632	Andrew Nelson
633	Margaret Seymour
634	Vincent McDonald
635	Howard Gibbard
636	Olivia Kelsey
637	Evelyn Stevenson
638	David Burtenshaw
639	Hilary Batty
640	Rudi Vogels

Number	Name
641	Alphonse Francis
642	Neil Harvey
643	Irene Hannah
644	Janet Marshall
645	Patricia Whiting
646	Mrs F J Nimmo
647	Gordon McFarlane
648	Paul McCulloch
649	Clare McGraw
650	Margaret Scott
651	Alison Wright
652	Deirdre Holding
653	Irene Grieveson
654	John Murphy
655	Fred Spurrier
656	Anne Comrie
657	Christine Taylor
658	Jane Colkett
659	Susan Strachan
660	David Dixon
661	Aly Boucher
662	Ian Jessiman
663	Susan Macgregor
664	Gillian Reid
665	Robert Anderson
666	Elizabeth Coulouris

Number	Name
667	Ian McIver
668	George Herriott
669	Peter & Mary McKay
670	Dr Martin Leiper
671	Joan & Robert Seebeg-Newtonfrise
672	Rhona Weir
673	Nola Elbogen
674	Margaret Paxton
675	Chris & Colette O'Neill
676	Agnes Hall
677	J Gordon
678	W M Farrell
679	Cheryl Snowdowne
680	Doreen Smith
681	David Linden
682	Dr Ian Henderson
683	Mary McGlade
684	David Wood
685	Mrs McMillan
686	Mary Galbraith
687	Mike & Nikki Addley
688	Sister Mary Murray
689	Paul Gillespie
690	S K Whitehead
691	Prof Burton

Number	Name
692	Jane McLeod
693	Peter Kiehlmann
694	Ray Allan
695	June McLellan
696	Douglas McIntyre
697	Jonathon & Karen Marks
698	Nina Cryne
699	Robert McAdam
700	Fr Paul Brooks
701	Jackie Forrest
702	Mary Bliss
703	David Green
704	Stephen Watt
705	Helena O'Donnell
706	Ian Rodger
707	Pat Leonard
708	Neil McNaught
709	Mike Peach
710	Anon
711	Michael Stainke
712	Katie Spencer- Nairn
713	Donna Graham
714	Linda Britton
715	John & Iona Simpson
716	Gerald Devlin
717	Agnes Donnelly

Number	Name
718	Charlene Brown
719	Ray & Pat Newton
720	Ann Brooks
721	Peter Gunn
722	Rowan Wood
723	Harry Gray
724	Alexander Milligan
725	Donald MacDonald
726	Douglas Lee-Murray
727	Lawrence Gilmour
728	Kevin Vaughan
729	James Torrens
730	Fabrice Herzog
731	Jim Halcrow
732	Michael Creechan
733	Charles McCluskey
734	Mary Lappin
735	Mary Forbes
736	Christine MacDonald
737	Mary Darroch
738	Alastair McGregor
739	Norah McKever
740	Helen Campbell-Borras
741	JMB
742	Joyce Buchan
743	Margaret Boyd

Number	Name
744	Jane Walton
745	Kenneth McNeil
746	David Lewis
747	Robert Watson
748	Williamena Yong
749	Brian Savage
750	Janet Leckie
751	Norman Khambatta
752	Jane Dochartaigh
753	Ann Brackenridge
754	Clare Darlseston
755	Jenny Tozer
756	Anon
757	Susan Wilcox
758	Gill Brooks
759	David Taylor
760	Susan Gole
761	Monica Humphries
762	E S Brown
763	John Anderson
764	Sheena Will
765	Jane & Kenneth Prentice
766	Libby Wilson
767	Margaret Smith
768	T A McAllister
769	J McCreath

Number	Name
770	Christine Clark
771	Angela Rennie
772	Ann & Neil Sweeny
773	Murdo & Christine McPhail
774	James Talloch
775	Mr & Mrs Heaton
776	Thomas & Flora Mullen
777	Jennifer Hepburn
778	Janet Cathie
779	Andrew Moore
780	W O'Neil
781	John Bingham
782	Mr Aitken
783	Clive Knewell
784	Peter & Marion Morrison
785	Rev'd & Mrs Graesser
786	Mrs Kobylarska
787	Margaret Stewart
788	Susan Blake
789	Dr Gilmour
790	Sheila Drummond
791	Dr J Shaw
792	Jessie Reid
793	Margaret Alexander

Annexe B

List of organisations (numbered as received) who responded to the Assisted Suicide (Scotland) Bill consultation

Number	Organisation
1	East Ayrshire Council
2	NHS Fife
3	BMA Scotland
4	Cross Reach
5	Dignity in Dying
6	Marie Curie Cancer Care
7	Scottish Council on Human Bioethics
8	Humanist Society Of Scotland
9	Royal Pharmaceutical Society Scotland
10	Dignitas
11	NHS National Service Scotland
12	Free Church of Scotland
13	Scottish Christian Party
14	The Muslim Council of Scotland
15	Evangelical Alliance
16	St Columba's Hospice
17	MND Scotland
18	Christian Concern

Number	Organisation
19	Alzheimers Scotland
20	Cornwall's Community Standards Association
21	Church of Scotland
22	Inclusion Scotland
23	SPUC Scotland
24	Scottish Youth Parliament
25	Royal College of Physicians Edinburgh
26	Stirling & Clackmannan-shire Shared Services
27	Nurses Christian Fellowship
28	Royal College of GPs
29	CARE for Scotland
30	Medical Education Trust
31	Methodist Church in Scotland
32	St Andrew's Hospice
33	Together for Short Lives
34	Catholic Parliamentary Office
35	Scottish Episcopal Church
36	Pro Life Alliance

Number	Organisation
37	Free Church of Scotland
38	People First Scotland
39	Scottish Partnership for Palliative Care
40	Christian Medical Fellowship
41	Highland Hospice
42	Care not Killing Alliance Scotland
43	Salvation Army
44	Strathcarron Hospice
45	Prince & Princess of Wales Hospice
46	United Free Church of Scotland
47	Nursing and Midwifery Council
48	Life over Death in Scotland
49	Alert
50	Catholic Medical Association
51	Crown Terrace Baptist Church Aberdeen
52	Community Pharmacy Scotland
53	South Lanarkshire Council
54	South Ayrshire Council
55	Friends at the End

Annexe C

List of organisations (alphabetical) who responded to the Assisted Suicide (Scotland) Bill consultation

Organisation	Number
Alert	49
Alzheimers Scotland	19
BMA Scotland	3
CARE for Scotland	29
Care not Killing Alliance Scotland	42
Catholic Medical Association	50
Catholic Parliamentary Office	34
Christian Concern	18
Christian Medical Fellowship	40
Church of Scotland	21
Community Pharmacy Scotland	52
Cornwall's Community Standards Association	20
Cross Reach	4
Crown Terrace Baptist Church Aberdeen	51
Dignitas	10
Dignity in Dying	5
East Ayrshire Council	1
Evangelical Alliance	15
Free Church of Scotland	12
Free Church of Scotland	37
Friends at the End	55
Highland Hospice	41
Humanist Society Of Scotland	8

Organisation	Number
Inclusion Scotland	22
Life over Death in Scotland	48
Marie Curie Cancer Care	6
Medical Education Trust	30
Methodist Church in Scotland	31
MND Scotland	17
Muslim Council of Scotland	14
NHS Fife	2
NHS National Service Scotland	11
Nurses Christian Fellowship	27
Nursing and Midwifery Council	47
People First Scotland	38
Prince & Princess of Wales Hospice	45
Pro Life Alliance	36
Royal College of GPs	28
Royal College of Physicians Edinburgh	25
Royal Pharmaceutical Society Scotland	9
Salvation Army	43
Scottish Christian Party	13
Scottish Council on Human Bioethics	7
Scottish Episcopal Church	35
Scottish Partnership for Palliative Care	39
Scottish Youth Parliament	24
South Ayrshire Council	54
South Lanarkshire Council	53
SPUC Scotland	23

Organisation	Number
St Andrew's Hospice	32
St Columba's Hospice	16
Stirling & Clackmannanshire Shared Services	26
Strathcarron Hospice	44
Together for Short Lives	33
United Free Church of Scotland	46