

END OF LIFE CHOICES

MARGO MACDONALD MSP

SUMMARY OF CONSULTATION RESPONSES

Introduction

The consultation document accompanying the draft proposal for the End of Life Choices (Scotland) Bill was issued on 8 December 2008 and ran until 9 March 2009. The intention of the proposal is to permit physician assistance to persons who wish to end their own lives.

It was issued to 139 organisations and individuals with an interest in the issue. The consultation document was also made available from a link on the Proposals for Members Bills webpage on the Scottish Parliament Website. [The Scottish Parliament: - Bills - Proposals for Members' Bills](#)

In addition the Member answered in excess of 250 requests for copies of the consultation.

General

In total 405 formal responses were received.

In advance of the launch of the consultation, the Member received 127 informal responses. A summary of these responses can be found at Annex A. Of these 127 responses, 94 supported the proposal and only 7 expressed opposition to the proposal.

Scottish Television (STV) conducted a survey on assisted suicide in the immediate aftermath of the consultation period. 75% of those questioned felt that people should have a right to choose when to die, 78% believed that family members should not be prosecuted if they have helped a loved one to die and 61% considered that doctors should have the right to prescribe fatal doses to those requesting assisted suicide.¹

Formal responses

There was considerable interest from a wide variety of groups on this matter. However, a significant number of respondents chose not to respond directly to the questions. Before looking at the detail contained in the responses to specific questions, it is useful to look at the influences behind the responses and some of the arguments presented. In general, responses were influenced by the following factors; a personal experience; a moral conviction; the religious faith of the respondent; a professional medical background; or membership of a campaigning group. These influences are considered in detail below.

¹ <http://news.stv.tv/home/83990-lead-story-assisted-suicide/>

Personal Experience

In all, 79 respondents to the consultation based their views on a personal experience. This personal experience varied from those who were suffering from a degenerative or irreversible condition themselves to those who had seen or were seeing close members of their family or friends afflicted with such a condition.

Of these 79 respondents, 63% of them believed that physician assisted suicide should be legalised. Many argued that palliative care had not been able to give their loved ones the comfort, dignity and relief that they had sought and the respondent wished that the option to request assisted suicide had existed. These respondents felt that while palliative care was of considerable importance, it was not always the answer. Other respondents argued that it should be about the quality and not the quantity of life and in that regard people who find life intolerable should be able to request assisted suicide. These respondents argued that to give those who find their life intolerable the option of assisted suicide would be compassionate and humane.

29 respondents who had had a personal experience argued against the proposal. A significant number of these respondents had seen close family and friends comforted by palliative care. A number also felt that palliative care had been able to provide dignity in their final days. Some also felt that to have the option of requested assisted suicide would have devalued the life of the person and that they deserved to have proper care in their final days. They considered that it would become eventually a duty to die rather than an option.

Moral Conviction

93 respondents based their support or otherwise for the proposal on a moral judgement. 65% of respondents considered that legalising physician assisted suicide was immoral while 35% argued that providing the option was the moral and humane conclusion to draw.

There were a number of common arguments expressed in the responses opposing the proposal. Firstly, respondents viewed what is proposed as murder, and they viewed it as immoral to ask physicians to commit murder. Secondly they saw the proposal as a 'slippery slope' toward non voluntary euthanasia and in support of this view, highlighted the expansion of the terms of the Abortion Act 1967. Thirdly, they considered that the proposal would undermine and devalue human life and make people more likely to feel like an expensive burden and therefore more prone to pursue assisted suicide whether or not they wished to do so. Finally, opponents of the proposal argued that in prioritising, what they considered, unrestricted personal autonomy no thought had been given to the negative impact this would have on wider society.

A number of respondents supported the proposal on moral grounds. Foremost amongst their arguments was that to provide the option of assisted suicide to persons suffering intolerable pain is the humane and moral thing to do. Responses invariably argued that we would be unwilling to let an animal continue to suffer so much, so why are we so willing to let human beings continue to suffer. A few responses argued that not providing assisted suicide was discriminatory in that it prevented those who are incapacitated from ending their lives when those who are not incapacitated are able to take their lives themselves.

A Religious Belief

72 respondents based their views on their religious beliefs. 70 of these responses expressed opposition to legalising physician assisted dying. The majority of these respondents based their opposition on the grounds that it is for God to give life and to take life away. The responses also promoted the sanctity of life and expressed the view that in participating in assisted suicide, physicians would be effectively committing murder. A significant proportion of the respondents expressing this view, argued that it would be better to promote palliative care. A number also drew attention to the experience of the Abortion Act 1967 and how it had in their view become more permissive.

One respondent who supported the proposal, identified themselves as a Christian, but did not feel this was incompatible with supporting assisted suicide and questioned how abortion could be legal, but not assisted suicide.

One other respondent, with a view informed by their religious belief, did not oppose the proposal, however, nor did they support the proposal. Although they expressed a number of concerns, their primary concern related to the inclusion within the proposal of persons who are not terminally ill, suffering from a degenerative condition, or unexpectedly incapacitated but who find their life to be intolerable.

Although not informed by their religious faith, a number of respondents expressed support for the proposal on the grounds that Scotland is not governed by the church and as such, questioned whether its views should hold sway on this matter. Furthermore, a number of respondents suggested that in their opinion if you take the arguments of the church to their logical conclusion physicians should not be intervening at all in the health of their patients.

A professional medical background

77 responses were informed by the professional medical background of the respondent. 63 of these responses expressed opposition to the proposal. The primary concern in approximately a quarter of these responses, related to the

qualifying condition for requesting assisted suicide, which the Member no longer proposes to include.²

There were, however, a number of other concerns expressed. The most common was that the focus for physicians should be on palliative care, rather than providing assisted suicide.

Other responses contended that to fulfil this role, physicians would be acting in contradiction to the Hippocratic oath³. It was suggested, however, by those supporting the proposal that in performing abortions, physicians are already acting in contradiction to the Hippocratic oath.

Another reoccurring argument against the proposal concerned the perceived danger posed to vulnerable and depressed people by this proposal. In particular, the issue of co-morbidity was highlighted. One response noted that 80% of cancer sufferers also suffer from depression. With this in mind, it was argued that while the person may be suffering from a degenerative, irreversible or terminal condition their judgement may still be impaired by depression, which may not always be detected by medical professionals.

Equally, however, a number of respondents suggested that rather than endangering the vulnerable and depressed this process could offer greater protection. Currently people who might find their lives intolerable might choose to take their own lives without discussing the matter. However, should a person seek assisted suicide then they will be required to discuss their situation with a medical professional and may instead receive medication and help.

More generally, amongst those opposing the proposal, there was concern that there was a lack of clinical safeguards.

Finally, amongst opponents of the proposal, there was concern about the position this would place doctors in and the damage it would do to the physician/patient relationship. The potential for misdiagnosis was also highlighted, particularly in relation to those diagnosed as terminally ill, but recover. It was stated that under the terms of this proposal the chance for this recovery would not be there.

Of the 14 medical professionals who expressed support for the proposal, the majority based their support on the experience of seeing patients in extreme pain and being unable to relieve that pain. They contended that being able to relieve this pain and suffering through assisted suicide would be the humane and compassionate thing to do.

² The qualifying condition no longer included was described in the following terms in the consultation document: "Patients" who are not terminally ill, suffering from a degenerative condition, or unexpectedly incapacitated but who find their life to be intolerable.

³ The Hippocratic Oath is an oath traditionally taken by physicians pertaining to the ethical practice of medicine.

Campaigning Group

The final identifiable group of respondents were those who were representing or were members of campaigning groups. 18 responses were submitted in this category with 14 supporting the proposal and 4 against.

It should be noted, however, that the campaigning group Care not Killing initiated a campaign against the proposal, inviting their members to respond to the consultation document. In inviting their members to respond they suggested a number of arguments that could be included within responses. While it is impossible to identify which responses were informed by this campaign, given the repetition of the arguments presented, it is probable that a proportion arguing against the proposal were informed by this campaign.

Other responses

There were 64 further responses, which did not fit into any of the above categories.

36 of these responses did not offer a reason for their position. 69% of this group expressed support for the proposal.

20 respondents offered no clear view. This group was a mixture of those who were unable to come to a view and organisations, including local authorities, who felt that this is a matter of personal conscience and as such did not commit to a view.

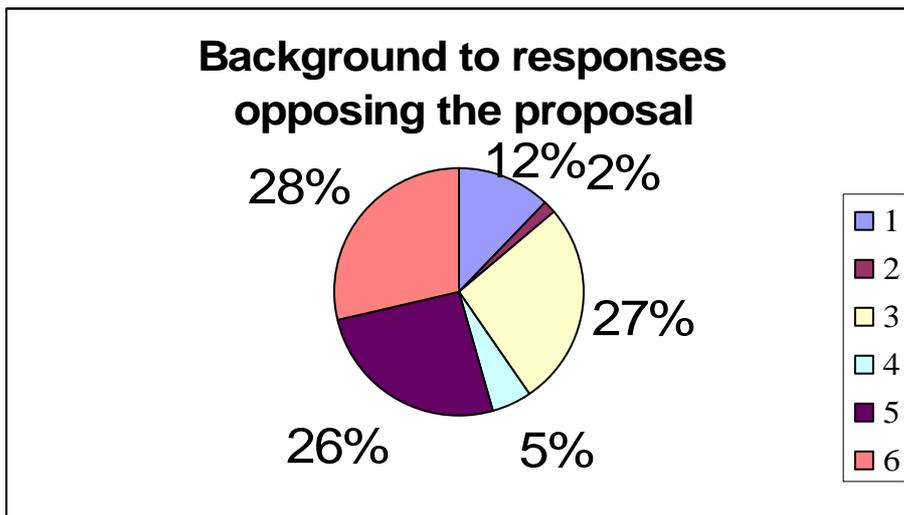
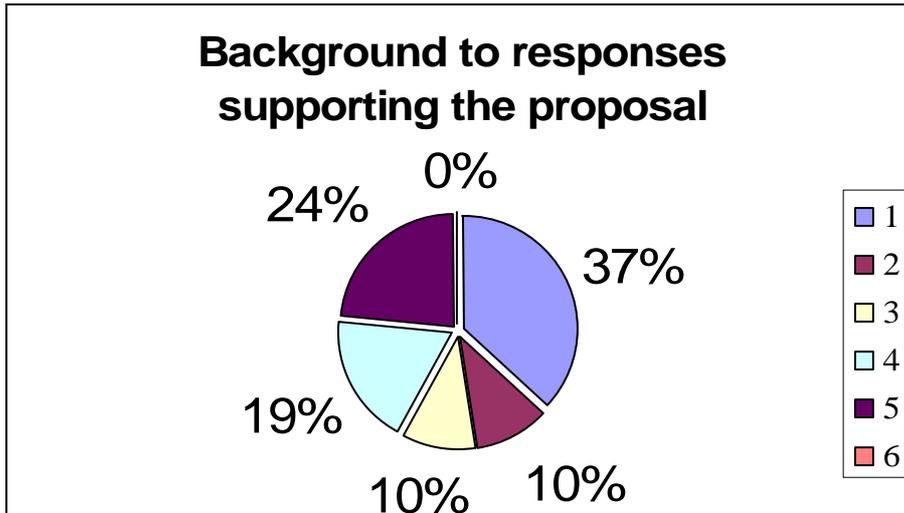
Finally seven respondents did not either agree or disagree with the proposal. However, they felt that it was important that an issue of this magnitude was properly debated.

Summary

Before turning to look at the responses to the questions, it is useful to look at the two charts below, which summarise where support for and against the proposal is drawn from.

So as to assist understanding of the following charts, please note the following numbers correspond to the following influences:

- 1 – Personal Experience
- 2 – Campaigning Group
- 3 – Medical Background
- 4 – Other
- 5 – Moral Conviction
- 6 – Religious Belief



Questions

Having considered the general arguments presented in the responses, this summary now looks at the responses to the questions posed in the consultation document.

Question 1

What are your views on applicability requirements?

In the consultation document it is proposed that in order to make a valid request for assisted suicide the person must meet the following qualifying conditions—

- Be resident in Scotland; and

- Can demonstrate to the attending physician that they are mentally capable in accordance with the Adults with Incapacity (Scotland) Act 2000.

The document further specified that the following three groups of people could request assisted suicide—

- Firstly, persons who are enjoying otherwise satisfactory health, but who have been diagnosed by a registered medical professional with degenerative, irreversible conditions.
- Secondly, persons who unexpectedly become incapacitated to a degree they find intolerable.
- And thirdly persons who are not terminally ill, suffering from a degenerative condition, or unexpectedly incapacitated but who find their life to be intolerable.

The majority of respondents supported the applicability requirements as set out in the consultation. 33 of the 54 respondents who answered this question felt that the requirements were appropriate. Amongst this group of respondents there was concern that any broadening of the terms would be inadvisable. In particular, there was concern that to do so could open Scotland up to “suicide tourism”.

With regard to residential eligibility, one respondent suggested that only Scottish residents should be eligible for the first five years before a review with a view to extending eligibility. Two additional respondents argued that all UK residents should be eligible.

Nine respondents who answered the question expressed opposition to the proposal and therefore did not consider that assisted suicide should be open to anyone.

Some concern was expressed about the extent to which those who could no longer express their wishes would be excluded from the Bill. One respondent suggested that in such circumstances, an assessment should be made by two speech and language therapists, a clinical psychologist, a communication aid specialist and a General Practitioner. Three other respondents considered the situation for dementia sufferers. Two of these three respondents argued for the use of living wills in such circumstances.

The majority of respondents were content with the applicability grounds as expressed in the consultation document. A number of respondents expressed concern about giving people who are not terminally ill, suffering from a degenerative condition, or unexpectedly incapacitated but who find their life to be intolerable the right to seek assisted suicide.

Question 2

From what minimum age should a person be able to specify an end of life choice?

The consultation document did not state a preferred age. It did, however, draw respondents' attention to the definition of an adult within the Adults with Incapacity (Scotland) Act, which defines an adult as someone who has reached the age of 16. However, the consultation document also suggested that persons under the age of 16 could be capable of making such decisions.

Of the 405 respondents, 59 responded to this question. Within these 59 responses there was a wide variety of views.

At one extreme there was one respondent who proposed that a person could seek assisted suicide from the age of nine, while at the other end of the spectrum, one person proposed that the minimum age should be 25.

For the most part respondents coalesced around the ages of 12, 16 and 18.

Five respondents suggested that a person should be able to seek assisted suicide at 12.

Ten respondents believed that at 16 persons should be able to seek physician assisted suicide. A further 14 respondents considered that 16 was appropriate, but they also considered that persons younger than 16 could seek assisted suicide if they could demonstrate that they understood what they were undertaking and had the consent of their parent or guardian.

Three respondents expressed a preference for 18, with a further three suggesting 18, but with scope for younger people to pursue assisted suicide if they demonstrated sufficient understanding and had parental or guardian consent.

One respondent suggested a minimum age of 21 while another respondent suggested that different and more rigorous conditions should apply for those between the ages of 10 and 22 than those older than 22.

A further eight argued that there should be no set age with each request for assistance being judged on its own merit. Of these eight, one suggested that for young people it should be for the Children's Panel to determine whether or not they are eligible to request assisted suicide.

Finally, eight of those who responded to the question opposed the Member's proposal and as such, suggested that there was not an age when a person could request assisted suicide.

Overall, the greatest number of respondents appear to have a preference for the minimum age to be set at 16, but with scope for

younger persons to seek assistance if they can demonstrate sufficient maturity and have the consent of their guardian or parent.

Question 3

Do you feel a waiting period of 15 days is enough? If not, what would be a sufficient waiting period and why?

The consultation proposes that a second valid request must be submitted to the attending physician no earlier than 15 days after the first request has been submitted.

Of the 60 people who responded to this question, 27 agreed that 15 days was sufficient.

Some felt that this period was too long. Two respondents felt that for those who had previously expressed a wish to end their suffering whether this was by Living Will, Advanced Directive or other means, should be able to circumvent this process. Another respondent felt that seven days was sufficient while one felt that if a previous wish had been expressed then five days would be adequate.

Equally, there were others who felt that 15 days was insufficient. Six respondents considered that 30 days would be sufficient and five that a month would be adequate. Another respondent suggested there should be a minimum waiting period of three weeks and maximum of four weeks. The longest waiting period suggested was six weeks.

A further group of 11 respondents expressed concern about what they considered to be the brevity of the waiting period, but did not express a view as to what the period should be.

It appeared, however, that there was most support for a waiting period of 15 days.

Question 4

Do you have a view on what constitutes a valid and documented request?

The consultation document proposes that in order to obtain physician assisted suicide, the person seeking assistance is required to make two valid and documented requests to their attending physician. The consultation document does not suggest what form this should take.

There were 59 responses to this question, expressing a variety of different views.

10 respondents highlighted the importance of having the document witnessed. Some of these respondents suggested who these witnesses should be and how many there should be. There were a variety of views, but there was general agreement that the witnesses should not have a personal interest and that there should be at least two.

A further 15 respondents, in addition to suggesting that the document should be witnessed, argued that it was important that persons seeking assisted suicide should be able to make their requests in a variety of different formats. It was highlighted that many of those seeking assisted suicide may not be able to write any more and as such, it was important that the option was there for an audio or video recording of the request.

Four respondents reflected the view that there should be a standard pro-forma for the request, perhaps one that could be downloaded and two stressed the importance of making the form simple and accessible.

Living wills were discussed by a number of respondents. Six respondents argued that living wills should be accepted as a valid documented request, particularly as they argued that many of those seeking assisted suicide would no longer be able to articulate their request.

There was some concern in the responses that relatives or others could pressure persons into seeking assisted suicide. With that in mind, three respondents advocated that the form should in some way provide assurance that the person was not placed under pressure in making this request.

There were also two respondents who felt that in validating the documented request, two or three physicians should be involved.

One respondent contended that there should be a point after which a valid and documented request ceases to be valid.

Finally, there were eight respondents who answered the question, but who were opposed to the Member's proposal and as such did not suggest a form for the request. Instead, in most cases, these respondents argued that no valid and documented request could provide the sufficient safeguards to protect the vulnerable and depressed.

Overall, however, the greatest number of respondents to this question contended that a valid and documented request should be able to be made in writing or recorded in audio or video. Whatever the format of the response, however, there was agreement that the request should be witnessed.

Question 5

Are there any other responsibilities you would add to the responsibilities of the attending physician?

In the consultation documentation it is proposed that an attending physician would consider the requests made for assisted suicide. The document specified the following responsibilities to be placed upon the attending physician:

- (a) Make or have made the initial determination, in writing, that the “patient” is capable and has made the request voluntarily;
- (b) Inform the “patient” of his or her medical diagnosis, his or her prognosis, and the potential risks associated with taking the medication to be prescribed;
- (c) Inform the “patient” of all feasible alternatives, including but not limited to, hospice care and palliative care;
- (d) Inform the “patient” that he or she may rescind the request to terminate life at any time and in any manner, even after the 15 day waiting period; and
- (e) Report the case to the review committee and provide patient’s medical record documentation requirements if assistance has been given to terminate the patient’s life.

There was a considerable range of views expressed; of the 44 respondents who answered this question 15 considered that the responsibilities as suggested in the consultation document were sufficient. Two further respondents restated the position in the consultation that physicians should be able to opt out of participating in the process of assisted suicide.

The next largest contingent group, accounting for 11 of those who answered the question, were those who were concerned or against physicians having this role. Respondents suggested that in undertaking this role physicians would be in contradiction of the Hippocratic oath. It was also suggested that the Bill would place physicians in an impossible position by asking them to make a judgement on whether or not to prescribe the necessary medication. With that in mind, it was suggested that physicians would not want to undertake this role.

Three respondents suggested a greater role for the attending physician in terms of recording the process. One respondent suggested that a monitored record should be kept of the physicians discussions with the patient, another that a recorded verbal record of the person’s request should be kept and one response considered that all records should be shared with the person.

There were three respondents who suggested that the responsibilities on the attending physician, as set out in the consultation document were too great. One respondent suggested that there should not be a requirement on the

attending physician to report to the review committee, another suggested that the process was too onerous and should be simplified and another that most of the responsibilities should lie with the consulting physician with the attending physician primarily concerned with preserving life.

There was some debate as to what extent the attending physician should involve family and others in this process. It was suggested by two respondents that the family should be consulted and that the person should be required to speak to a minister of their declared faith. At the other end of the spectrum two respondents argued that the family should not be involved, that the person's request should be respected and that the physician should not seek to impose their own views.

Question 6

Are there any other responsibilities you would add to the responsibilities of the consulting health professional?

The consultation document proposed that in those instances where persons who are not terminally ill, suffering from a degenerative condition, or unexpectedly incapacitated but who find their life to be intolerable request assistance, the attending physician should involve a consulting physician in the process.

The consultation document ascribed the following responsibilities to the consulting physician—

- (a) Examine the “patient” and confirm, in writing, that the “patient” is capable and has made the request voluntarily; and
- (b) Confirm the “patient” is aware of all feasible alternatives, including but not limited to, hospice care and other palliative care.

The consultation document also proposes that if the attending physician questions the mental capacity of the person to understand the nature of the request they should seek the involvement of a consulting physician.

Many of the responses advocated a different or expanded role for the consulting physician.

Of the 41 responses to this question, 13 considered that the role as defined in the consultation document was appropriate. Five expressed opposition to the role on the grounds that it was asking physicians to act in a manner contrary to the Hippocratic oath and that it did not provide adequate safeguards, while one respondent thought that the involvement of an attending physician sufficient.

The remaining respondents all saw a role for a consulting physician different to that described in the consultation document.

Firstly, two respondents considered that there needed to be clarity within the Bill as to who these consulting physicians should be. One respondent contended that whoever undertakes this role should have counselling skills.

A number of other respondents proposed additional responsibilities to be placed upon the consulting physician. Two respondents considered that it should be incumbent on the consulting physician to submit their notes to the review committee. Another two suggested that it should be a responsibility of the consulting physician to ensure that the person has not been coerced into making this request.

A further two respondents contended that the consulting physician should have a responsibility to understand feasible alternatives and convey these to the person. An alternative response proposed that there should be a duty on the consulting physician to consult with a suitably qualified health professional rather than necessarily having an understanding of all the feasible alternatives.

Another respondent felt that it should be for the consulting physician rather than the attending physician to play the primary role in this process. There were conflicting views on how the consulting physician and attending physician should work together. One response argued that there should be a requirement within the Bill for the attending physician and consulting physician to discuss their diagnosis, while two respondents contended that they should operate in isolation.

Overall, 23 respondents considered that the role and responsibilities of the consulting physician should change from those set out in the consultation document.

Question 7

If the proposed Bill did not specify a review committee, do you have any views on alternative arrangements or safeguards?

The final question concerned the existence of a review committee, a body proposed in the consultation document to ensure that proper processes have been followed. It would undertake this process post mortem.

Although the question was posed in terms of what would you propose as a safeguard if a review committee was not specified, the majority of respondents to the question believed that a review committee would be the most appropriate safeguard. 17 respondents contended that a review committee should be established within the Bill. Among these responses a number of suggestions were made as to the make-up of the review committee. Invariably responses proposed that the review committee should

include representatives of the medical and legal profession while some also argued that it should include members of the public and clergy.

A further eight responses also advocated the establishment of a review committee, however, these responses argued that to provide a stronger safeguard, it would be more appropriate for the review committee to be involved prior to the act of assisted suicide.

A number of respondents suggested alternative safeguards. Four respondents suggested that General Practitioners not involved in the case or in the practice where the person is registered should undertake the review. One respondent argued that the Local Health Authority could fulfil this role while another suggested that this could be a role for the Care Commission. Safeguards in place at Dignitas⁴ in Switzerland and contained within the Cremation (Scotland) Regulations⁵ were also highlighted. Another response suggested that the existence of an Advance Directive would be a sufficient safeguard. More generally, one respondent suggested that the Parliament should review the legislation three years after its enactment.

Four respondents did not think that a review committee would be necessary while one thought it would not be necessary in every case.

Six respondents expressed concern as to whether or not the review committee could provide sufficient safeguards. In particular three of these six did not think it provided adequate clinical safeguards and one questioned whether it would do any more than check the sufficiency of the paperwork.

⁴ Swiss laws on assisted suicide clearly state that a person who assists in an assisted suicide can only be prosecuted if they are motivated by self-interest: an important legal point. As a result, Dignitas ensures that it acts as an entirely neutral party by proving that aside from non-recurring fees, they have absolutely nothing whatsoever to gain from the deaths of its members. This is done in the following manner: the person who wishes to die meets several Dignitas personnel, in addition to an independent doctor, for a private consultation. The independent doctor assesses the evidence provided by the patient and is met on two separate occasions, with a time gap between each of the consultations. Legally admissible proof that the person wishes to die is also created, *i.e.* a signed affidavit, countersigned by independent witnesses. In cases where a person is physically unable to sign a document, a short video film of the person is made in which they are asked to confirm their identity, that they wish to die, and that their decision is made of their own free will, without any form of coercion. Such evidence of informed consent is entirely private and is not intended to ever be made public. The evidence is created and stored purely for use in any possible future legal dispute regarding the person who wishes to die, *e.g.* allegations that someone was forced to commit suicide. Finally, a few minutes before the lethal overdose is provided, the person is once again reminded that taking the overdose will surely kill them. Additionally, they are asked several times whether they want to proceed, or take some time to consider the matter further. This gives the person the opportunity to stop the process. However, if at this point the person states that they are determined to proceed, a lethal overdose is provided and ingested.

⁵ Under the terms of the Cremation (Scotland) Regulations the cremation of body parts are prohibited until one Medical Referee is satisfied of several matters: that the parts were removed in the course of a post-mortem examination carried out on the deceased, that the death has been duly registered, and that a proper application for the cremation has been submitted. In cases where the Medical Referee cannot be satisfied of such matters, the Scottish Ministers may still authorise the Medical Referee to allow the cremation of body parts.

Overall, however, the majority of respondents favoured the creation of a review committee with a sizeable proportion of those favouring its involvement not at post-mortem, as described in the consultation document, but before the act of assisted suicide.

Conclusions

The Member very much welcomes and appreciates the interest that has been demonstrated in her proposal.

It is appreciated that this is a matter of personal conscience and as such it is to be expected that some people will have a moral, ethical, professional or religious opposition to the proposal.

In finalising her proposal, the Member will take account of the views expressed and suggestions made in the course of the responses.

The Member draws particular attention to those responses to the consultation, which were informed by a personal experience and notes the predominance of supporters of the proposal within these responses.

The Member also draws attention again to the findings of the STV poll and the informal responses and highlights the strong public support for assisted suicide that they evidence.

THE END OF LIFE CHOICES (SCOTLAND) BILL

MARGO MACDONALD MSP

SUMMARY OF INFORMAL RESPONSES

Introduction

The consultation document accompanying the draft proposal for the End of Life Choices (Scotland) Bill was issued on 8 December 2008 and ran until 9 March 2009. The Bill seeks to allow persons, in certain circumstances, to request assistance to end their lives from a qualified, registered physician. The Bill seeks to clarify the law surrounding physician assisted suicide and would protect the physician from prosecution.

In addition to 405 formal responses to the consultation, prior to the launch of the consultation, the Member in charge of the Bill received 127 informal responses, commenting on the proposal.

These informal responses are not related to the formal consultation and were not submitted with a view to publication. Respondents are not listed or identified within this summary, however, the responses offer an indication of the support for the Members proposal. The responses also set out some of the key arguments in favour of the proposal, as well as those arguments presented by the minority who opposed the proposal.

General

As previously noted, the Member who has lodged this proposal received 127 informal responses relating to her proposal. Of these, 94 expressed support for the proposal, 7 indicated opposition to the proposal and the remaining responses were either undecided or unclear.

The majority of responses came from Scotland, but given the high profile given to this proposal, it was not surprising to find that 36% of the responses came from outwith Scotland.

Responses came into the Member both before and after the nature of the proposal became clear. As such, a number of the responses were submitted without knowledge of the exact nature of the proposal and as such some of the issues noted in them are no longer relevant.

In general, however, the responses, presented arguments for and against the proposal, which are still of relevance.

The following sections consider firstly the arguments presented in favour of the proposal, before looking at some of the grounds on which people opposed the proposal.

Arguments in Favour

As previously noted, of the 127 informal responses, 94 expressed support for the proposal. Of the remaining 33, only seven were opposed to the proposal. The others were either unclear in their response or as yet undecided.

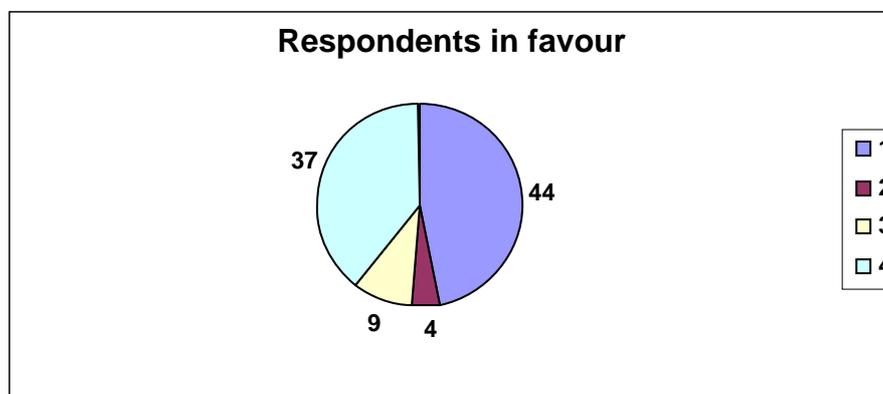
Before looking at the nature of the responses, as before, it is useful to look at the motivation of those who wrote to the member in charge of the Bill expressing support for the proposal.

Background of respondents

Those who wrote to the Member expressing support were motivated by a number of different factors. 44 had either had a direct or indirect experience of a terminal or degenerative illness or intolerable situation, which had led them to support assisted suicide. Four supported the proposal on religious grounds, nine on medical grounds and 37 supported the proposal on moral grounds.

This is expressed in the chart below. So as to assist understanding of the following charts, please note the following numbers correspond to the following influences:

- 1 – Personal experience
- 2 – Religious grounds
- 3 – Medical background
- 4 – Moral grounds



Location

The Member's proposal has received considerable UK wide media coverage and as such a significant proportion of the responses favouring the proposal were drawn from outwith the UK. 34% of respondents in favour of the proposal were drawn from England and 2% from outwith the UK.

Arguments

There were a variety of different arguments presented in favour of the proposal, a number of which reoccurred throughout the informal responses.

Set out below are some of the most frequently occurring arguments set out in the responses—

- It should be your right to choose when you want to die.
- Medical science is progressing so quickly that we are living longer than our bodies were designed for.
- It should be an issue of quality, not quantity of life.
- Given that we live in a largely secular society, why should the law still reflect the position of the church?
- Why should people have to suffer unnecessarily?
- Why should people be forced to travel abroad to fulfil their wishes?
- We put suffering animals out of their misery, why should the same not apply to humans?
- The law currently discriminates against the incapacitated as they are not able to take their own life in the way that an able bodied person would be able to do so.
- If physicians are able to withdraw medication to hasten death, then why should they not be able to administer it to achieve the same effect?

Arguments against

Seven respondents expressed opposition to the proposal. This opposition was expressed at a time when the consultation had not been issued and as such, there was a degree of uncertainty about the nature of the proposal. Some of these concerns were based on the assumption that anyone could assist someone to commit suicide. However, with the confirmation in the draft proposal that only physician assisted suicide would be legalised, some of these concerns may have been alleviated.

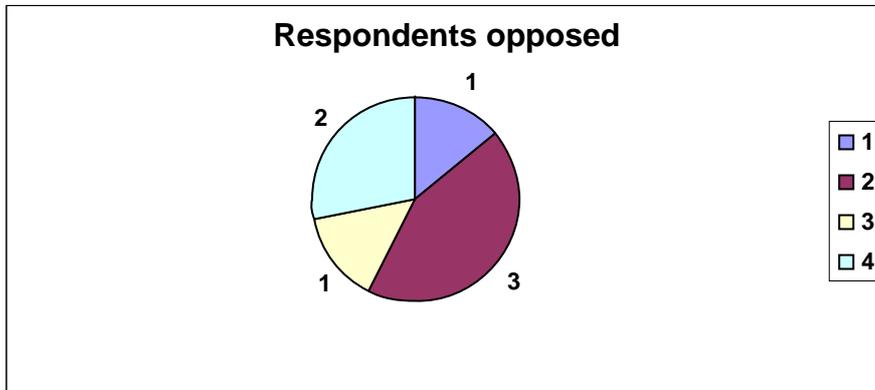
Background of respondents

Like those who wrote to the Member expressing support for the proposal, those opposed to it were motivated by a number of different factors. Only one respondent had had a personal experience of degenerative condition, which had persuaded them against this proposal, one opposed on religious grounds, three on medical grounds and two on moral grounds.

This is expressed in the chart below. So as to assist understanding of the following charts, please note the following numbers correspond to the following influences:

- 1 – Personal experience
- 2 – Religious grounds

- 3 – Medical background
- 4 – Moral grounds



Location

The Member's proposal has received considerable UK wide media coverage and as such a significant proportion of the responses favouring the proposal were drawn from outwith the UK. All of those who responded expressing opposition to the proposal came from Scotland.

Arguments

There were a number of arguments presented against the proposal. A number of these would appear to have been superseded by the terms of the draft proposal.

With this in mind, the following outstanding concerns about the Bill remain—

- Will it encourage people to pursue this route early on in a condition when there may still be some potential for recovery?
- Given the experience of Dr Harold Shipman and other such cases, is it possible to draft legislation on such a sensitive subject that will not be abused?
- Will it be assumed that people suffering from terminal or degenerative conditions will follow this route?
- Will it make the life of someone who is disabled or incapacitated seem less worthwhile?
- Are there dangers associated with prior consent? How could we be sure that the person still felt this way if incapacitation came some time after giving prior consent?