I have a number of concerns over the above Bill. They are as follows:

1. **CROSSES A MORAL BOUNDARY** I believe that this legislation would cross a moral boundary. It would completely invert and threaten the relationship between patient and doctor and undermine the role of medicine in society.

2. **PROPOSED LAW NOT NEEDED?** Why is this proposed law needed? Physical suffering can now be controlled and alleviated with appropriate palliative care.
   
   a. It is important to point out that the effective treatment of pain guarantees that no one will suffer a painful death. Health-care providers must make every effort to ensure that the available medications to eliminate or control pain are provided to a patient.
   
   b. From a moral perspective, a physician should responsibly administer medications to control or alleviate pain even when doing so may hasten death. The physician’s intention should not be to kill the patient but to relieve pain effectively with the medicines available.
   
   c. No matter how ill a patient is, we never have a right to put that person to death. Rather, we have a duty to care for and preserve life.

3. **WEAKEST AND MOST VULNERABLE WILL BECOME PRONE** Passing an assisted suicide law would threaten the weakest and most vulnerable among us, especially the elderly and the terminally ill. It would be a dramatic breach of Scotland’s longstanding commitment to protect and care for those most in need.

   a. **THIS BILL CONTRADICTS A PRIMARY PURPOSE OF LAW IN AN ORDERED SOCIETY** To sanction the taking of innocent human life is to contradict a primary purpose of law in an ordered society. A law or court decision allowing assisted suicide would demean the lives of vulnerable patients and expose them to exploitation by those who feel they are better off dead. Such a policy would corrupt the medical profession, whose ethical code calls on physicians to serve life and never to kill. The voiceless or marginalized in our society—the poor, the frail elderly, racial minorities, millions of people who lack health insurance—would be the first to feel pressure to die.

   b. **PREJUDICE AGAINST DISABLED PEOPLE** Why are people with disabilities worried about assisted suicide? Many people with disabilities have long experience with prejudicial attitudes on the part of able-bodied people, including
physicians, who say they would "rather be dead than disabled." Such prejudices could easily lead families, physicians and society to encourage death for people who are depressed and emotionally vulnerable as they adjust to life with a serious illness or disability. To speak here of a "free choice" for suicide is a dangerously misguided abstraction.

c. **REMOVAL OF FUNDAMENTAL INALIENABLE RIGHT TO LIFE.** No matter what the ailment he/she suffers from, a human being is always human, and always has a right to life which nobody, of any philosophical, political, or religious persuasion ever is able to take away. In fact, it is precisely when life is afflicted by weakness and illness that it is all the more deserving of our care

d. **DANGEROUSLY INADEQUATE LANGUAGE - “LIVE INDEPENDENTLY”** Under the bill, to be eligible a person would either have been diagnosed as terminally ill, or be permanently physically incapacitated to such an extent as not to be able to live independently. What does this mean, independently? What could it be misrepresented to mean? Consider how the clause in 1967 abortion law which allows women to abort if their physical or mental health is threatened was abused to allow a landslide of deaths?

**QUOTING THE BRITISH MEDICAL ASSOCIATION (BMA)**

Although some may argue that the scope for abuse is less with assisted suicide than with euthanasia because of the need for the patient's informed cooperation, a Canadian Senate enquiry of 1995 found the potential for abuse or undue influence to be unacceptable. In its current guidance on end of life issues, the BMA Ethics Department quotes the views of a Canadian doctor canvassed during that national debate:

... 'knowing my own weaknesses and recognizing the weaknesses I have seen around me in the practice of medicine, within hospitals, and within the health care system, I can simply say to those who would ask so eloquently for these freedoms that, on the ground, in the trenches where it matters, the first to die would be the weak and inarticulate, the defenceless, not the strong-willed, those possessed of unattractive situations or stories of particular hardship. It would be the ordinary people whose continued existence is resented by unsympathetic relatives or an unsympathetic health care system'.

http://www.bma.org.uk/ethics/end_life_issues/Euthanasiaphysicianassistedsuicide.jsp?page=3#8

**VIEWS OF AMERICAN MEDICAL PROFESSION.** In America, the Medical Association holds that "physician-assisted suicide is fundamentally incompatible with the physician's role as healer." The AMA, along with the American Nurses Association, American Psychiatric Association and dozens of other medical groups, has
urged the Supreme Court to uphold laws against assisted suicide, arguing that the power to assist in taking patients’ lives is "a power that most health-care professionals do not want and could not control.

4. **THE INFLUENCE OF COST** How does cost enter into this issue? In an era of cost control and managed care, patients with lingering illnesses may be branded an economic liability, and decisions to encourage death can be driven by cost. It has been indicated by Acting U.S. Solicitor General Walter Dellinger in urging the Supreme Court of the US to allow states to ban assisted suicide: "The least costly treatment for any illness is lethal medication.

5. **DEPRESSED COMPETENT, TERMINALLY ILL PEOPLE WHO SAY THEY REALLY WANT ASSISTED SUICIDE?** "What about competent, terminally ill people who say they really want assisted suicide? Suicidal wishes among the terminally ill are no less due to treatable depression than the same wishes among the able-bodied. When their pain, depression and other problems are addressed, there is generally no more talk of suicide.

6. **REMOVAL OF ORDINARY MEANS TO SAVE LIFE?** To what lengths are we required to go to preserve life? No religion or state holds that we are obliged to use every possible means to prolong life. The means we use have traditionally been classified as either "ordinary" or "extraordinary."

"Ordinary" means must always be used. This is any treatment or procedure which provides some benefit to the patient without excessive burden or hardship.

"Extraordinary" means are optional. These are measures which do present an excessive burden.

The distinction here is NOT between "artificial" and "natural." Many artificial treatments will be "ordinary" means in the moral sense, as long as they provide some benefit without excessive burden. It depends, of course, on the specific case in point, with all its medical details. Procedures providing benefit without unreasonable hardship should be obligatory; others are not.

The core evil of assisted suicide/euthanasia is that an individual or group of people think they have the right to put someone else to death.

7. **THE EUROPEAN CONVENTION ON HUMAN RIGHTS** The European Convention on Human Rights recognises the right to life as inalienable, that it cannot be removed by any authority or relinquished by any person.”

Hugh McCann
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