

An [Assisted Dying for Terminally Ill Adults Bill](#) has been proposed in Scotland by Liam McArthur MSP to enable competent adults who are terminally ill to be provided at their request with assistance to end their life. The following is our submission to the public consultation.

Aim and approach

1. Which of the following best expresses your view of the proposed Bill?

- Fully supportive
- Partially supportive
- Neutral (neither support nor oppose)
- Partially opposed
- **Fully opposed**
- Unsure

Please explain the reasons for your response.

Our Patrons and Members include experts in the law, the legislative process, medicine, mental health, ethics and other disciplines related to the end-of-life debate. They do not hold identical views on all aspects of the debate, but they share a common concern that public safety is of paramount importance in this area and that some of the ideas that are being put forward - for example, that doctors should be licensed by law to supply lethal drugs to terminally ill patients to take their own lives - are not compatible with this and would put vulnerable people at serious risk of harm. We recognise that deficits in care exist but have seen no evidence that these will be ameliorated by such legislation. We fully respect the motivations of those who may take a different view but find the evidence from other legislatures that have gone down this road confirm our conclusions that such legislation particularly jeopardises people at a vulnerable time and undermines the professional duty of care to patients and their families.

2. Do you think legislation is required, or are there other ways in which the Bill's aims could be achieved more effectively? Please explain the reasons for your response.

No, the current law in Scotland accurately and conscientiously reflects the perceptions which, as a society, we have of suicide - that, while those who attempt to take their own lives should not be punished, suicide itself should not be encouraged or assisted. Those contemplating taking their own life must be treated with great empathy and the causes of their profound distress must be urgently addressed.

The law's combination of deterrence with discretion means that the incidence of illegal action is small and generally of a nature where the Lord Advocate does not consider prosecution to be in the public interest. It is not an oppressive law; it is a law with a stern face but an understanding heart. Claims that the law is not being enforced or that it inhibits doctor-patient dialogue or that it encourages amateur assistance with suicide do not stand up to serious scrutiny.

As well, if the aim is to eliminate “needless suffering”, this could be more effectively achieved through the improvement of palliative and end of life care services, with equitable access early in the course of a person’s illness. This would enable and encourage doctors, and society at large, to provide excellent care for patients until the moment of death, with support for families facing bereavement, rather than ending life weeks, months or even years prematurely.

3. Which of the following best expresses your view of the proposed process for assisted dying as set out at section 3.1 (Step 1 - Declaration, Step 2 - Reflection period, Step 3 - Prescribing/delivering)?

- Fully supportive
- Partially supportive
- Neutral (neither support nor oppose)
- Partially opposed
- **Fully opposed**
- Unsure

Please explain the reasons for your response, including if you think there should be any additional measures, or if any of the existing proposed measures should be removed. In particular, we are keen to hear views on Step 2 - Reflection period, and the length of time that is most appropriate.

The proposed process is weak and insufficient. It will do little to safeguard people from abuse and could be easily exploited. Currently doctors are obliged to have open realistic conversations with patients and to ascertain their wishes in care. Such conversations reinforce a commitment to care and recognises areas of distress that need to be tackled. However, responding to a request for lethal drugs at face value gives the subliminal message that the doctor feels this patient would be better off dead with the real risk of shortcuts in care. The power-differential in the doctor patient relationship also gives a cloak of medical beneficence to the action when such shortcuts exist.

The declaration should be submitted, along with any relevant evidence, to the Court whose responsibility it should be to judge eligibility. Doctors do not know the personal or social factors in an individual's life beyond what is recorded in the clinical record. It is the role of the Court alone to balance the rights of some against the protection of others, not of individual doctors.

The requirement of a 14-day reflection period following approval of assisted suicide does not seem enough to permit sober reflection or to exclude coercive pressures - we are given longer to

change our minds about buying clothes or white goods. Reducing the reflection period further if a person is expected to die within 30 days prompts another question: why is it so essential to hasten the death of someone who is thought to be about to die anyway? There seems to be a mentality underlying these proposals that it is of supreme importance that a terminally ill person should be able to bring about his or her own death, rather than recognising that in the last days or even hours of people's lives they can live well with surprising vibrancy. It is little short of absurd to be thought that, where someone's death is expected to be imminent, we should shorten the cooling-off period even further so that they can inflict death on themselves, rather than ensuring they have the support they need as they are dying of their disease.

Further, there is a fundamental legal and ethical issue at stake. Since the abolition of capital punishment, outside war no citizen is permitted by law to assist the death of another. For capital punishment, the capacity to assist the ending of life was given to very few people, and under the most strict controls. Is Parliament comfortable about allowing a large and loosely controlled cohort, even doctors, to act as assistants to death, when palliative care is a realistic alternative?

The attempt at predicting life expectancy fails to recognise that prognostication is a very inaccurate and probabilistic art, and that even when people are thought to be in the last three days of life, at least 3% are not in fact dying. Such legislation will inevitably result in many people ending their lives very early in the mistaken belief that death is far closer than it actually is.

The short cooling off period fails to recognise the fluctuating nature of a wish for death, as many people say they are glad they are still alive when supported out of those times of despair and once they realise they are still of value and of worth even though they are ill.

Regarding the prescribing and delivery of lethal drugs, the proposals are silent as to what lethal drugs will be used and the potential complications of these drugs are. In other jurisdictions the lethal drugs used have never been subject to proper scientific scrutiny. Previously, massive doses of barbiturate were used, but a shortage of supply and escalating prices have meant different drug combinations are now being tried. In Oregon, a mixture of four different classes of drug have been used, but these drug combinations have longer median times to death than the barbiturates which are no longer readily available. The combinations are intended to induce sedation with toxic levels precipitating a heart arrhythmia and death by asphyxia. In the Oregon reports, information on complications is only reported when a physician or other health professional is present at the time of death. These reports record a complication rate of 6.7% over 23 years, with a complication rate of 7.5% in 2020. This rate suggests a different picture to the 'idealised death' portrayed by those campaigning for such legislation.

It is appropriate that the healthcare professional must check that the person still has capacity before ingesting the lethal drugs. However, there is concern as to how the healthcare professional is supposed to respond in the event that complications arise. For example, if a person is vomiting would they be expected to clear their airways (which would be a resuscitative

procedure)? Similarly, in the event of the patient convulsing and becoming cyanosed there will be an emotional conflict for the healthcare professional as their normal 'first aid' response would not be appropriate when the desired outcome is death, rather than to restore a person to living well.

Finally, it is unclear as to whether it is proposed that all assisted suicides would be recorded as an 'assisted death' or as a result of the person's terminal illness. If the former, then the underlying disease or diseases must also be recorded. If the latter, then it is extremely worrying as this would be requiring doctors to falsify the death certificate "in the interests of privacy". This would make investigation particularly difficult if any criminal actions behind the death were later suspected and would prevent proper scrutiny of processes around such deaths. It would also be impossible to ascertain that reporting requirements were being complied with.

4. Which of the following best expresses your views of the safeguards proposed in section 1.1 of the consultation document?

- Fully supportive
- Partially supportive
- Neutral (neither support nor oppose)
- Partially opposed
- **Fully opposed**
- Unsure

Please explain the reasons for your response.

The proposal contains a number of criteria that have to be met before lethal drugs may be supplied. In reality, however, these 'safeguards' are vague symbolic assurances that are neither effective nor verifiable.

First, the definition of 'terminal illness' is problematic. The proposal defines terminal illness as that suffered by those deemed by doctors as 'unable to recover', regardless of the time they have left to live. Inevitably, the language of such a proposal opens the door to incremental expansion of eligibility to those with non-terminal illness or disability. Under the definition given, it appears that anyone with a chronic condition which may not cause death but from which a person will not recover, or an incurable and progressive disease such as insulin-dependent diabetes which can be modified but is not curable, would be eligible for an assisted death in Scotland. The definition of terminal illness is a dangerous loophole because it fails to define eligibility clearly as it potentially includes the vast majority, if not all, of chronic illnesses and long-term disorders.

Secondly, the assessment of mental capacity is left to the assessing doctors with referral for psychiatric examination limited to cases where doubts as to mental capacity exist, as is the case in Oregon. However, Oregon's experience has shown that referrals of applicants for physician-assisted suicide for psychiatric examination are in practice rare, despite estimates that 1 in 6

patients who receive lethal drugs meet the criteria for a diagnosis of depression (Ganzini, 2008). In 2020, only 1.2% of patients who received a lethal prescription were referred for psychiatric evaluation. Specialist psychiatric examinations should be made a requirement for every person who requests an assisted death, particularly as assessments of capacity are difficult and the majority of clinicians are inadequately skilled at detecting some types of impaired capacity.

Thirdly, those most involved with caring for a person at the end of life have testified that the experience of pain control is radically different from the promise of pain control and that patients seeking assistance to die without having experienced good symptom control cannot be deemed fully informed. Therefore, there should be a requirement that an applicant for 'assisted dying' must receive specialist palliative care input to ensure the patient's request reflects informed consent, before confirming a wish to receive 'assisted dying'.

Fourthly, it is proposed that the two doctors will be responsible for detecting any coercion and pressure on a person's decision to take lethal drugs. It is unclear, however, how clinicians will be able to detect what occurs behind the closed doors of a person's home, as clinicians often have little knowledge of the patient and their circumstances beyond the clinical consultation. It is essential that an objective assessment of financial and other pressures, such as friction in close family, is conducted, but doctors are not in a position to state with legal certainty that such pressures do not exist.

A request for lethal drugs may appear voluntary but, in reality, can result from various pressures. Undue influence in the form of elder abuse and coercive control are widespread and often go undetected. People also worry about the cost or burden of their care on hard-pressed families or beneficiaries. Incremental increases in the number of people requesting 'assisted dying' also suggests that the 'right to die' can itself become a subtle coercive influence on patients. Yet, there are no required minimum steps that a doctor must take to exclude coercion. The duration of some of the physician-patient relationships in Oregon is reported to have lasted "0 weeks" prior to the assisted suicide request. Doctor-shopping, as seen in Oregon, means that instances of coercion or abuse remain undetectable; notably, in Oregon, state elder abuse has soared by 13 per cent in the space of a year.

A settled wish to die is not defined in this proposal. The statement 'I wish I was dead' and a true wish to die are often very different. The former is usually an expression of seeking assurance that the person is still of value and has a role in life. There has been powerful research that shows that the way a person is cared for can enhance their sense of dignity and personal value, while it can be undermined by the attitude of others, both those in direct contact with the person and from attitudes in wider society.

It is also important to consider how doctors view this responsibility. A 2020 survey of BMA members showed that the majority of those licensed to practice and closest to terminally ill and dying patients – those in palliative care, geriatric medicine, oncology, and GPs – do not support

legalisation. A majority of BMA members said they would not participate in such practices. Research reveals that the primary motivation for clinicians refusing to participate in assisted suicide is not religious or moral beliefs, but the burden of having to determine patient eligibility and fear of psychological and emotional repercussion. Medical practitioners themselves are aware of the ambiguity of the presented eligibility criteria and are hesitant to take on such responsibility. Balancing rights and enforcing them is the proper province of the courts, not of the consulting room.

Finally, a reporting process which relies on simple forms filled out by the doctor and health care professional, and without any record of how the assessment was conducted, would make independent audit impossible and be inadequate in a determination of potential malpractice.

5. Which of the following best expresses your view of a body being responsible for reporting and collecting data?

- **Fully supportive**
- Partially supportive
- Neutral (neither support nor oppose)
- Partially opposed
- Fully opposed
- Unsure

Please explain the reasons for your response, including whether you think this should be a new or existing body (and if so, which body) and what data you think should be collected.

If clinicians are licensed to prescribe lethal drugs to patients, it would be of paramount importance that sufficient data is collected and critically analysed. An important record is that of how the consultations were conducted – the current availability of body-worn video recorders, such as used routinely by some paramedics and in emergency departments, would make audit of such conversations through a confidential inquiry format feasible and would ensure protection of the doctor from accusations of being too ready to end life for a variety of reasons including NHS pressures on resources.

Other centrally collated data should include basic characteristics of the patients and their terminal condition which qualifies them for the prescription of lethal drugs, whether they have received palliative care and for how long, the patients' end of life concerns, details of the prescribing physician and their medical specialty, which drugs are prescribed to bring about death, and information on the dying process itself, such as the time from ingestion to unconsciousness and death and the presence of complications.

It is notable, however, that in jurisdictions where assisted suicide is legal, effective and reliable data collection has proved largely unattainable. There are inherent dangers in requiring that the forms are filled out only by the doctors who have agreed to prescribe the lethal medication,

because doctors are not going to report where they fail to adhere. The experience in Belgium estimates that 40% of euthanasia cases go unreported for a variety of reasons, including the workload of filling in a form. Additionally, instances in which clinicians have refused any prior requests due to prognosis, capacity, or the presence of coercion go undocumented. It is no surprise that misconduct goes unreported, as no doctor is likely to self-report their own mistake, and there is no triangulation by requiring reports from others involved, such as nurses and close relatives or friends who were with the person as they ended their life.

6. Please provide comment on how a conscientious objection (or other avenue to ensure voluntary participation by healthcare professionals) might best be facilitated.

A person or place which conscientiously objects to assisting suicide must have no obligation to participate in the process. An individual doctor or management board of the hospice, hospital, clinic, care home, or other facility where the person has made a written declaration to self-administer lethal drugs must be under no obligation to participate in any part of the process. The General Medical Council requires signposting of a person making a legal request for a procedure to which there is a conscientious objection. However, an organisation must have the right to declare openly that it refuses to provide assisted suicide or euthanasia without jeopardising its funding; it is notable that in Canada hospice-closure has been reported because no provision for a conscience clause for organisations was put in place.

No recognised health body or organisation which operates in the field of health or social care (or both) should take into account a doctor's refusal to participate in procedures around assisted suicide when making any determination about the employment, promotion, appointment or career of that doctor.

If an establishment receives funding from the public sector, legislation must stipulate that the public sector body funding cannot be withdrawn on the grounds that an organisation has a conscientious objection.

Financial implications

7. Taking into account all those likely to be affected (including public sector bodies, businesses and individuals etc), is the proposed Bill likely to lead to:

- **a significant increase in costs**
- some increase in costs
- no overall change in costs
- some reduction in costs
- a significant reduction in costs
- don't know

Please indicate where you would expect the impact identified to fall (including public sector bodies, businesses and individuals etc). You may also wish to suggest ways in which the aims of the Bill could be delivered more cost- effectively.

Evidence from overseas suggests that assisted suicides increase exponentially where legislation is in place. The workforce costs involved will be significant, particularly as the healthcare professional may wait several hours until the patient dies and would need to be replaced in the clinical team to avoid jeopardising other patients. Other costs relating to the education, training and commissioning of specialist healthcare practitioners to participate in assisted dying would be a necessary result from these proposals. Taking into account the number of doctors who would abstain from participating in assisted dying - which, according to the 2020 BMA survey, would be 45% - alongside the current pressures on the NHS because of the pandemic, the level of resource and extra funding this proposed bill would require if enacted would be substantial.

We fear that this bill would increase costs, but in all the wrong places, as the requisite funding would be an ineffective and dangerous investment which would do nothing to solve current deficits in the health and care system. The funding that is most necessary at the moment is funding to improve specialist palliative care services to support patients approaching the end of life. The health service is on its knees as a result of COVID-19 and does not have the capacity to stretch its workforce into a practice that has too many flaws to be workable. Diverting funding away from the critical care needs of patients at the end of life drastically undermines the fundamental ethic at this nation's core which has always sought to protect the value of life.

Proponents of a change in the law make conflicting claims regarding funding: they say that palliative care investment is complementary to assisted dying. But on the other, they applaud potential savings, citing the healthcare budget projections in Canada. This is a glaring contradiction.

Evidence shows that palliative care investment does not accompany assisted dying legislation. An analysis of specialised palliative care services in 51 European countries over the last 14 years reveals that the average growth in palliative care services in countries with 'assisted dying' is slower than countries without such legislation. Notably, Belgium and the Netherlands appear to have experienced no growth in palliative care services since 2012. Whilst an increase in palliative care funding is desirable, with or without legislation, experience demonstrates that legalisation would hinder, not help, palliative care investment growth.

Account must also be taken of the evidence from Canada that specialist palliative care professionals are leaving services because they do not want to be involved in any aspect of assisted suicide and euthanasia. Workforce shortages would worsen, further pushing up costs and a requirement for locum provision in services whilst losing clinical expertise.

If resources are diverted away from other services to the processes of 'assisted dying', for many hastening death would not become one end-of-life option, but the prominent option as choices in care dwindle. This has been seen in Canada where some patients have gone to Court to try to have their care needs met, rather than opt for euthanasia.

If the Bill proposal is serious about making access to palliative care a prerequisite to a signed declaration, and proponents believe in simultaneously increasing the quality of good palliative care, then such legislation should not commence until specialist palliative care services are core funded in all areas, fully integrated with all general medical and surgical services, as well as across the community and care homes.

Equalities

8. What overall impact is the proposed Bill likely to have on equality, taking account of the following protected characteristics (under the Equality Act 2010): age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation?

- Positive
- Slightly positive
- Neutral (neither positive nor negative)
- Slightly negative
- **Negative**
- Unsure

Please explain the reasons for your response. Where any negative impacts are identified, you may also wish to suggest ways in which these could be minimised or avoided.

The introduction of assisted dying will undermine the very legislative framework that protects the equal rights of all people. The principle that all life is valuable and must be protected will no longer apply to all persons. Clinicians and society at large will be enabled to promote ageist and biased agendas through the albeit subtle or subconscious suggestion that not every life is of worth and that, as a society, we have a duty to each other, to provide care and support at all times.

There are certain populations who are particularly vulnerable to coercion and face substantial threat by the legalisation of assisted dying, such as the elderly and disabled people. Instances of elder abuse are widespread and often go undetected. In Oregon, elder abuse has grown by 13% in just one year and in 2020 53% of those who died through taking lethal drugs described feeling a burden on their friends, family and caregivers as an end of life concern. A request for lethal drugs may appear voluntary but, in reality, can result from various pressures including the cost or burden of care, influence from family members, and psychological or emotional distress. In the UK, elder abuse is even more likely to go undetected because basic data on elder abuse in the UK

is lacking, creating “systematic invisibility.” The Crime Survey for England and Wales still excludes people older than 74 and does not survey group residences, thereby excluding elderly people in care homes.

In jurisdictions where assisted dying is legal, reports acknowledge the existence of abuse (Steck et al, 2014) and explicitly describe higher proportions of vulnerable individuals being offered an assisted death. Case reports of assisted deaths in intellectually disabled people are a particular concern (Tuffrey-Wijne I, Curfs L, Finlay I, Hollins S, 2018). Further, because all reporting mechanisms rely on the prescribing doctor to self-report, it is inevitable that instances of discrimination and unconscious bias are largely undetected.

Concern has been voiced that vulnerable populations, such as those with complex needs, progressive disability and those who are socially marginalised, will also come under threat of subtle coercion through unconscious bias in health and legal professionals. In a debate on Baroness Meacher’s Assisted Dying Bill Lord Hastings said: “I speak as an advocate of many black people and black organisations, and evidence earlier this year from the Joint Committee of the House of Commons and the House of Lords, which was looking into equal opportunities in health, revealed the fear that black communities, and especially women, have of unfair decisions made by health practitioners, as well as the massive fear in limited minority communities about judicial decisions—especially those of High Court judges.”

The current law exists to protect the vulnerable. Scandals involving the elderly or disabled people remain rife, and we are still struggling to ensure 15-year-old capacity legislation across the UK is appropriately applied to protect people with any impairments of capacity.

Sustainability

9. In terms of assessing the proposed Bill’s potential impact on sustainable development, you may wish to consider how it relates to the following principles:

- living within environmental limits
- ensuring a strong, healthy and just society
- achieving a sustainable economy
- promoting effective, participative systems of governance
- ensuring policy is developed on the basis of strong scientific evidence.

With these principles in mind, do you consider that the Bill can be delivered sustainably?

- Yes
- **No**
- Unsure

Please explain the reasons for your response.

The strongest, healthiest and most just societies are the ones which look after the weakest and most frail. To suggest that assisted dying legislation would do justice to the most vulnerable in society would be a worrying betrayal of the principles of care and protection that characterise the NHS in this country. What is needed is not a death-focused system which becomes the obvious route for those suffering mentally or physically at the end of life, but an improved and integrated health and social care system devoted to supporting the health and social needs of the people in our society who need it most.

As mentioned above, diverting effort away from the improvement of the quality of life and care of all dying persons towards efforts to provide an assisted suicide/euthanasia service fundamentally undermines the values of a society that stands in solidarity with its most vulnerable members.

An assessment of the possible financial implications is dealt with more comprehensively above, but it should be noted that the solution to the problem of economic unsustainability does not lie with legalising assisted dying. Yet the cost efficacy of specialist palliative care is proven as it relieves costs from the acute sector as well as improving quality of life for patients. Experience from overseas demonstrates that palliative care investment does not improve where assisted suicide is legal.

We are unaware of any long-term study of the impact of assisted suicide or euthanasia on the long-term health and wellbeing of the bereaved.

With regards to participative systems of governance, these proposals offer scant detail as to the provision of regulations, monitoring and scrutiny commitments, reporting obligations or indeed as to what happens in disputed cases. As it appears, the courts are not involved, neither is a social work assessment. It is unclear how any form of abuse or coercion, from family or any other personal contact would be identified. In order to detect any criminal activity, monitoring needs to be robust and maintain a high level of scrutiny, particularly with regards to who it is that is being given, and is giving, lethal drugs and the background to that decision. Data must be held securely for a minimum of 25 years. It is a grave concern that in Oregon the data is disposed of after a year making most forms of such coercion unidentifiable. In the Netherlands, reporting through the Dutch independent review committees provides post-event reporting information but does not provide any qualitative assurance over the consultation in which the decision to end life was taken. The proposals laid out here for Scotland do not represent or promote a participative system of governance, but one that will open a door to manipulation, coercion and injustice.

It is not clear that any strong scientific evidence, apart from patchy opinion polls, has formed the basis of the policy outlined in the proposals. Regarding the lethal drugs involved in the assisted dying process, there is little factual evidence as to their safety.

Since the European Commission restricted the sale of barbiturates to the US due to their use in judicial executions, the majority of assisted suicides in Oregon are brought about using

experimental combinations referred to as “DDMA” and “DDMP”. The extent to which previous and current assisted dying drugs are safe and effective is unknown, as there have been no controlled trials or observational studies. Experimental drug combinations, like “DDMA” and “DDMP” have not undergone standard drug evaluations.

Patients who ingest lethal drugs can experience distressing complications. In Oregon in the last two years of the 31% of assisted suicides with available data, there is a complication rate of 8.2%. Time from drug ingestion to death has taken up to 47 hours in 2019, up to 8 hours in 2020, but there is a report of death taking 108 hours after ingestion. Patients in the United States have been asked to ingest the contents of 90-100 barbiturate pills. The result is a mixture so bitter and potent that many patients struggle to ingest the liquid and can experience choking, coughing and vomiting. In Canada’s oral MAiD drug protocol, another drug regimen recommended is a mixture of phenobarbital, chloral hydrate and morphine. Chloral hydrate is known to be caustic to oral and gastric mucosa and can cause painful burning in the throat and stomach. In the context of judicial execution, it has been suggested that intravenous barbiturate overdose combined with a curare-like paralysing agent as used in many euthanasia’s may result in distressing and painful deaths, even though they appear peaceful because the person cannot move a muscle. In a study of over 200 autopsies of executed prisoners, of those killed with a lethal dose of pentobarbital 84% showed signs of flash pulmonary oedema (their lungs were filled with fluid and weighed several times the weight of normal lungs).

It is clear that the proposals of this bill are built on shaky evidence and do not offer confidence that, if enacted, the bill would protect the interests of society as a whole, nor that it would guarantee the idealised deaths that proponents suggest

General

10. Do you have any other additional comments or suggestions on the proposed Bill (which have not already been covered in any of your responses to earlier questions)?

The proposed bill is not going to solve deficits in care, but it may result in people not being offered the care that they need at the end of life. Inadequate integration of palliative care with acute services leaves many patients unable to benefit from modern techniques - such as palliative radiotherapy and surgical – which could benefit them. Advanced pain management techniques such as nerve blocks are also underutilised. Diverting resources away from these areas to involve staff in processing eligibility and providing lethal drugs will only worsen this situation.

The evidence in jurisdictions where assisted suicide and euthanasia has been in place for some time, such as the Benelux countries, reveals that many doctors have changed their minds and become critical of the reality of implementation. Doctors have reported a major emotional toll from such involvement. The UK already has a workforce that is exhausted and demoralised; it does not have capacity or resilience to take on additional complex legal responsibilities to end life

when all efforts during the pandemic have been to enhance and protect quality of life, while accepting the inevitability of death.

It is of concern that this consultation is being conducted when the detailed content of the legislation and underlying documentation, for example codes of practice and ethical guidelines, have not been disclosed. Legislators are not being adequately informed of the complex but important details of the suggested regime.