

# Proposed Assisted Dying for Terminally Ill Adults (Scotland) Bill

## Introduction

A proposal for a Bill to enable competent adults who are terminally ill to be provided at their request with assistance to end their life.

The consultation runs from 23 September 2021 to 22 December 2021.

All those wishing to respond to the consultation are strongly encouraged to enter their responses electronically through this survey. This makes collation of responses much simpler and quicker. However, the option also exists of sending in a separate response (in hard copy or by other electronic means such as e-mail), and details of how to do so are included in the member's consultation document.

Questions marked with an asterisk (\*) require an answer.

All responses must include a name and contact details. Names will only be published if you give us permission, and contact details are never published – but we may use them to contact you if there is a query about your response. If you do not include a name and/or contact details, we may have to disregard your response.

Please note that you must complete the survey in order for your response to be accepted. If you don't wish to complete the survey in a single session, you can choose "Save and Continue later" at any point. Whilst you have the option to skip particular questions, you must continue to the end of the survey and press "Submit" to have your response fully recorded.

Please ensure you have read the consultation document before responding to any of the questions that follow. In particular, you should read the information contained in the document about how your response will be handled. The consultation document is available here:

[Consultation Document](#)

[Privacy Notice](#)

I confirm that I have read and understood the Privacy Notice attached to this consultation which explains how my personal data will be used.

On the previous page we asked you if you are UNDER 12 YEARS old, and you responded Yes to this question.

If this is the case, we will have to contact your parent or guardian for consent.

If you are under 12 years of age, please put your contact details into the textbox. This can be your email address or phone number. We will then contact you and your parents to receive consent.

Otherwise please confirm that you are or are not under 12 years old.

*No Response*

## About you

Please choose whether you are responding as an individual or on behalf of an organisation.  
Note: If you choose "individual" and consent to have the response published, it will appear under your own name. If you choose "on behalf of an organisation" and consent to have the response published, it will be published under the organisation's name.

on behalf of an organisation

Which of the following best describes you? (If you are a professional or academic, but not in a subject relevant to the consultation, please choose "Member of the public".)

*No Response*

Please select the category which best describes your organisation

Third sector (charitable, campaigning, social enterprise, voluntary, non-profit)

**Optional: You may wish to explain briefly what the organisation does, its experience and expertise in the subject-matter of the consultation, and how the view expressed in the response was arrived at (e.g. whether it is the view of particular office-holders or has been approved by the membership as a whole).**

0.1 The Anscombe Bioethics Centre (formerly the Linacre Centre for Healthcare Ethics) is an academic research institute that engages with ethical questions arising in clinical practice and biomedical research. The Centre was established in 1977 and is thus the oldest centre for biomedical ethics in the United Kingdom. It is currently based in Oxford but its remit covers Scotland and Ireland as well as England and Wales. Its governing board is constituted to require representation from Scotland and Ireland as well as from England and Wales.

0.2 The Centre is a Catholic foundation and informed by the Catholic intellectual tradition. However, it does not draw only or primarily on revealed sources (such as the Bible) and is not directed only to the Catholic community. It also offers ethical analysis on questions of public policy affecting all citizens. When commenting on public policy, as in relation to the current consultation, it arrives at its response by considering fundamental ethical principles that can be known from reason and experience, in addition evidence relevant to the specific proposals and analysis of those proposals.

0.3 The Centre has engaged in questions about the ethics of end of life care since its foundation and contributed to the debate over euthanasia through the writing of a report on the topic in 1982 and submitting evidence to the House of Lords Select Committee on Medical Ethics in 1993. A prominent member of the working group that produced that first report was the philosopher Elizabeth Anscombe. The report and submission, together with contributions by the legal philosophers John Finnis and John Keown, amongst others, are reproduced in Luke Gormally (ed.) *Euthanasia, Clinical Practice and the Law*, London: Linacre Centre, 1994.

0.4 The present submission has been drafted by the current director of the Centre, David Albert Jones, who, in addition to directing the Centre is also professor of bioethics at St Mary's University in Twickenham. He is also vice-chair of the Ministry of Defence Research Ethics Committee and an examiner and lecturer for the Society of Apothecaries Diploma in the Philosophy of Medicine, has served on the steering group of the End-of-Life Care Audit – Dying in Hospital and was a member of a working party of the General Medical Council which helped draft its 2010 guidance on Treatment and Care Towards the End of Life.

0.5 Professor Jones has a longstanding research interest in this area and his publications include *Approaching the End*, Oxford: Oxford University Press, 2007; 'Is there a logical slippery slope from voluntary to non-voluntary euthanasia?' *Kennedy Institute of Ethics Journal* (2011) 21.4: 379-404; 'How does legalization of physician assisted suicide affect rates of suicide?' *Southern Medical Journal* (2015) 108.10: 599-604 (co-author with D. Paton); *Euthanasia and Assisted Suicide: Lessons from Belgium*, Cambridge: Cambridge University Press, 2017 (contributor and co-editor with C. Gastmans and C. Mackellar); 'Assisted dying and suicide prevention' *Journal of Disability & Religion*, 22.3 (2018): 298-316; 'Anscombe on euthanasia as murder' in R. Teichmann (ed.) *The Oxford Handbook of Elizabeth Anscombe*, Oxford: Oxford University Press, forthcoming; and 'Euthanasia, assisted suicide and suicide rates in Europe: A reply to Lowe and Downie', *Journal of the Ethics of Mental Health*, forthcoming.

0.6 He submitted both written and oral evidence to the Health and Sport Committee in relation to the Assisted Suicide (Scotland) Bill (2014/2015). Since then he has submitted written evidence to the External

Please select the category which best describes your organisation

Panel on Options for a Legislative Response to Carter v Canada (2015); written and oral evidence to the New Zealand Health Select Committee Investigation into Ending One's Life (2016/2017); written and oral evidence to the New Zealand Parliamentary Justice Committee on the End of Life Choice Bill (2018); written evidence to the Committee on Justice on the Dying with Dignity Bill 2020 [Ireland], (2021) and written and oral evidence to the Standing Committee on Law and Justice on the New South Wales Voluntary Assisted Dying Bill (2021). He was one of three academics providing content advice for the Jersey Citizens' Jury on Assisted Dying (2021).

Please choose one of the following:

I am content for this response to be published and attributed to me or my organisation

Please provide your Full Name or the name of your organisation. (Note: the name will not be published if you have asked for the response to be anonymous or "not for publication". Otherwise this is the name that will be published with your response).

Anscombe Bioethics Centre

Please provide details of a way in which we can contact you if there are queries regarding your response. Email is preferred but you can also provide a postal address or phone number.

We will not publish these details.

## **Aim and Approach - Note: All answers to the questions in this section may be published (unless your response is "not for publication").**

Q1. Which of the following best expresses your view of the proposed Bill?

Fully opposed

### **Please explain the reasons for your response.**

1.1 Fatal ambiguities in the language of 'assisted dying'

1.1.1 The first concern raised by this bill is its proposed title. The Assisted Dying for Terminally Ill Adults (Scotland) Bill is, in its essentials, substantially the same as the Assisted Suicide (Scotland) Bill 2013, put forward by the late Margo McDonald MSP. Both Bills were designed to enable competent adults who are terminally ill to be provided at their request with the means to end their life. The proposed Bill replaces the transparent language of the earlier Scottish Bill with the euphemistic language of former Bills introduced in England.

1.1.2 The issue here is not only an aesthetic preference for plain speaking over euphemism. The phrase 'assisted dying' is euphemistic because it avoids drawing attention to the most controversial aspects of the proposal, that is intention and causality. The phrase is deliberately ambiguous between assisting someone who is dying, for example by providing palliative care at the end of life, and 'assisting' someone by causing them to die intentionally, either by giving them the means to end their life (assisted suicide), or by intentionally ending their life at their request (voluntary euthanasia). This obscurity also creates the added problem of ambiguity between who it is that causes the death, that is between assisted suicide and voluntary euthanasia.

1.1.3 The consultation document states that 'For the purposes of this consultation, Assisted Dying means the practice whereby a person diagnosed with a terminal illness is given the choice to end their own life, by means of medication provided by a doctor for that purpose' (Foreword, page 3). However, this definition is contradicted by the footnote which states that 'it is appropriate to use assisted

Q1. Which of the following best expresses your view of the proposed Bill?

dying as the umbrella term here' (footnote 1 emphasis added). Used as an umbrella term, 'assisted dying' is not limited to those with terminal illness, is not limited to the person taking their own life, and is not limited to assistance by a physician. This is clear when the footnote also states that assisted dying is sometimes 'referred to as medical aid in dying'. Medical aid in dying is the preferred term in Canada and is not restricted to the terminally ill, or to self-administration or to the involvement of a physician. A nurse practitioner can administer the lethal injection to someone with a chronic physical condition and, from 2023 this is due to be extended to people with mental health conditions. Canada has not yet followed the Netherlands and Belgium in extending euthanasia and assisted suicide to competent minors but this is being actively considered.

1.1.4 The overwhelming majority of 126 references to 'assisted dying' in the consultation document are not to the restricted use in the present Bill (i.e., physician assisted suicide for the terminally ill) but the umbrella use of the term for euthanasia and/or assisted suicide for people with terminal and/or chronic-physical and/or mental illness by a physician and/or non-physician (such as a nurse practitioner). This use of the term is not necessarily problematic if it is clear how it is being used, but it is important for MSPs to be aware that the phrase is being used in this way, especially when evaluating evidence from other jurisdictions. It is also important that the term is used consistently through the document. Hence, for example, if 'assisted dying' or 'assisted death' are used in this umbrella fashion then it cannot be said that assisted dying/death is not 'assisted suicide' because a person is 'only able to request an assisted death if they have a terminal illness' (footnote 1). In relation to jurisdictions which allow this practice, the majority of 'assisted deaths' occur in countries where it is not restricted to terminal illness (i.e., in the Low Countries, Canada and Switzerland).

1.1.5 Related to this, there is a contradiction in the consultation document in that footnote 1 states that the word 'suicide' is not appropriate where a person has 'a terminal illness that will end their life'. Yet, later in the document it is stated that people 'with terminal illness have an increased likelihood of attempting to end their own life' and footnotes 34 and 35 contain an extended discussion of the percentage of 'suicides' who have a terminal illness. As it is true and important to say that some people with terminal illness die by suicide then it seems that when they have been given the means to end their life by a doctor, then they die by assisted suicide. I had a colleague who died by suicide and who would, in some jurisdictions, have qualified for 'assisted dying'. He died by taking a lethal dose of medication prescribed for other reasons. That was suicide. If he had died from taking a lethal dose prescribed for that purpose that would have been assisted suicide (for further discussion on this point see D.A. Jones 'Assisted dying and suicide prevention' *Journal of Disability & Religion*, 22.3 (2018): 298-316). Whether someone's condition is terminal, however this term is defined, or degenerative or chronic, should not obscure the reality that when someone intentionally takes their own life, their death is suicide, and if a doctor has provided the means to enable this action, this is a physician assisted suicide (PAS).

1.1.6 The first jurisdiction to pass legislation to enable competent adults who are terminally ill to be provided at their request with the means to end their life was the state of Oregon. The first official report on that practice begins with the sentence 'On October 27, 1997 physician-assisted suicide became a legal medical option for terminally ill Oregonians.' The second official report begins with the sentence, 'In November 1997, approval of the Death with Dignity Act made Oregon the only state allowing legal physician-assisted suicide (PAS).' The third official report begins with the sentence 'In 1997, physician-assisted suicide (PAS) became legal in Oregon.' The fourth report begins: 'Physician-assisted suicide (PAS) has been legal in Oregon since November 1997, when the Death with Dignity Act was approved by Oregon voters for the second time'. The fifth report begins: 'Physician-assisted suicide (PAS) has been legal in Oregon since November 1997, when the Death with Dignity Act was approved by Oregon voters for the second time (see History, page 6).' The sixth report, and the seventh report, and the eighth report all begin with wording identical to that in the fifth report.

1.1.7 It is not until the ninth report, released in March 2007, that official reports drop the phrase 'physician assisted suicide'. Instead, the ninth report begins with the rather cumbersome sentence, 'Under Oregon's Death with Dignity Act (DWDA), terminally-ill adult Oregonians are allowed to obtain and use prescriptions from their physicians for self-administered, lethal medications.' Subsequent reports followed this new wording, more or less. The most recent report begins, 'The Oregon Death with Dignity Act (DWDA) allows terminally ill Oregonians who meet specific qualifications to end their lives through voluntary self-administration of a lethal dose of medications prescribed by a physician for that purpose'. (For all annual reports see <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>).

1.1.8 Between 2006 and 2007 there was no change in the criteria for who was eligible to receive a lethal dose of medications for the purpose of ending their life, nor any other change in the dose to be prescribed, nor any other changes in procedure connected to the Bill. The change of terminology was made for political reasons, perhaps in recognition that at that stage no other state had followed Oregon to allow physician assisted suicide for the terminally ill (the second state to pass such legislation was the neighbouring state of Washington in 2008).

1.1.9 In relation to this shift, the American philosopher Gerald Dworkin, a longstanding vocal advocate of the legalisation of PAS wrote: 'I should note that the use of the term "Physician-assisted suicide" is now politically incorrect, for tactical reasons. I understand that the popular prejudice against suicide makes it more difficult to rally support for the bills I favor. And even some potential users of such measures object to their death-certificate reading "suicide." But to list the cause of death, as many such bills do, as the underlying disease process seems to me simply a lie.' (<http://www.3quarksdaily.com/3quarksdaily/2015/06/california-dying.html>) Similarly the British philosopher and euthanasia advocate, the late Mary Warnock, stated that she preferred to use 'the terms "euthanasia" and "assisted suicide" – not sanitising these words with euphemisms like "assisted dying"' (C. Brewer, M. Irwin (eds.) *I'll See Myself Out, Thank You Newbold on Stour: Skyscraper*, 2015, p.130).

1.1.10 If the representatives of the Scottish people are being asked to embrace legislation to allow, for the first time, a physician to prescribe a lethal dose of medication for purpose of enabling a patient with a terminal illness to take their own life, the name of the Bill should make clear that this constitutes 'physician assisted suicide' for the terminally ill.

1.1.11 While the term 'assisted dying' is unhelpfully ambiguous, the consultation document is to be commended for seeking an umbrella term for different forms of euthanasia or assisted suicide. This enables the document to include statements such as 'over 200 million citizens worldwide now have access to assisted dying' (page 4). For the purposes of this consultation this submission with use

## Q1. Which of the following best expresses your view of the proposed Bill?

EAS (euthanasia and/or assisted suicide) as an umbrella term and PAS for physician assisted suicide. If the term 'assisting dying' is used in this response, for example, to reflect the wording of the Bill or to reflect arguments used by others, then it will be clarified whether this refers to the umbrella term 'assisted dying'(EAS) or the Bill 'assisted dying'(PAS).

1.1.12 If 200 million citizens live in countries where 'assisted dying'(EAS) is legally accessible this implies that 7.7 billion people live in countries where EAS is not legally accessible. For the most part, this is not because parliaments and courts in these countries have never been asked to consider EAS but is more typically because EAS has been considered and rejected, often repeatedly.

### 1.2 Considering evidence from all relevant jurisdictions

1.2.1 In relation to the evidence, it is important to consider all those jurisdictions where EAS is legal, even if they have a different form of legislation than the Bill currently being proposed for Scotland. This is for a number of reasons:

1.2.2 If evidence were restricted to jurisdictions with the same form of EAS proposed in the Scotland (i.e., 'assisted suicide'(PAS) for terminally ill adults) then the only place that could provide evidence would be the United States, and within the United States only those handful of states with more than five years experience (i.e., Oregon, Washington, Vermont, Montana and California). This would exclude potentially relevant and useful evidence from other jurisdictions, and especially from the Netherlands, Belgium, Switzerland and Canada. The consultation document does indeed cite evidence from these jurisdictions but does not make explicit why evidence from these countries is relevant.

1.2.3 Evidence for all EAS jurisdictions is relevant because the step to legalise intentional ending of life by or with the assistance of doctors, is of much greater medical, ethical and political significance than the details of the law by which it is introduced. The diverse practices of the Low Countries, Switzerland, Canada and the US state of Oregon have something fundamental in common that distinguishes them from law and medical practice in most of the world. They all permit 'assisted dying' (EAS), in some form or other. This is shown by the way that not only opponents but also advocates commonly group these jurisdictions together in discussion of the issues.

1.2.4 Furthermore, because the differences between these jurisdictions in relation to law and practice are less significant than what they have in common, once the great step is taken to allow EAS in some form, it is a much smaller step to increase the scope or application of EAS. Extensions of the legislation may come as a result of court cases or of further amendments to the law or changes in how the law is applied in practice, but in one way or another restrictions in the law are gradually eroded or abandoned. The country that shows this most clearly is Canada and MSPs should consider how that country (which culturally and on matters of health and welfare is more similar to Scotland than the USA is) moved very rapidly from permitting 'medical aid in dying' (which in Canada is equivalent to EAS) for those whose 'natural death has become reasonably foreseeable' (itself a very vague formulation) to allowing it for chronically sick and disabled people whose death is not 'reasonably foreseeable'. The law is due to be extended in 2023 to include advance decisions and also mental illness (as in the Netherlands and Belgium) though this latter move is meeting some resistance.

1.2.5 A further reason that evidence should be considered from all countries with some form of EAS is that a change in the law can have an impact beyond what is included in the law itself. For example, there is good evidence that terminal sedation is being used in Belgium as an alternative means to bring about a patient's death (see Sterckx, S., & Raus, K. 'The practice of continuous sedation at the end of life in Belgium: how does it compare to UK practice, and is it being used as a form of euthanasia?' in Jones, D.A., Gastmans, C & MacKellar (eds) Euthanasia and assisted suicide: Lessons from Belgium. Cambridge: Cambridge University Press, 2017, pp. 86-100). The practice of euthanasia has undermined the fundamental principle of medical ethics that physicians should not intentionally end the lives of their patients. Once this principle has been compromised then other forms of intentional ending of life are able to be considered. Furthermore, once intentional ending of life begins to be practised by other means, outside the structures of the law, then it can be done even without the requirements of the law, and hence without request of the patient. All that is needed is a judgement of the doctor that death would be in the patient's best interest and, if so, then it can be sought intentionally, by whatever means is available to a doctor. This explains why a law which defines euthanasia by reference to a voluntary request from the patient can lead to widespread ending of life without request, for which there is evidence in Belgium (see D.A. Jones 'Euthanasia and Assisted Suicide in Belgium: Bringing an End to Interminable Discussion' in D.A. Jones, C. MacKellar and C Gastmans (eds) Euthanasia and Assisted Suicide: Lessons from Belgium. Cambridge: Cambridge University Press, 2017, pp. 235-257).

1.2.6 Again, evidence from different countries with some form of EAS can be used comparatively. For example, many jurisdictions adopt some form of reporting and review procedures. However, it is extraordinarily rare for these procedures to result in prosecution, and when this happens it is generally because a physician has been open about a flagrant breach of legal requirements. These structures rely on self-reporting and so physicians who act outside the law have an incentive not to report the death as falling under the law. The small number of prosecutions is sometimes held up as evidence that these laws are working as they should, but provides no evidence for actions that physicians choose not to report. The problem of the reliance of official reports on self-reporting can be mitigated to some extent by independent research into medical practice in countries with EAS. It is because of such research that we can be confident that and intentional life-ending without request and under-reporting of euthanasia are both widespread in Belgium. However, the amount of relevant research that is done in different jurisdictions is very variable. There is much less independent research into end of life practices in Oregon or other states in the United States than there is in the Netherlands and Belgium. This is a reason to examine evidence where it exists, because a lack of evidence tells us nothing if the lack of evidence simply reflects a lack of research.

### 1.3 Developments since 2015

1.3.1 The summary of the evidence provided in the consultation document is derived from the skeleton argument of a legal case *Omid T v Secretary of State* in 2018 which itself was derived from evidence presented in the *Carter v Canada* case in the court of first instance in 2012. The consultation document lists eight academics and clinicians who all gave evidence in favour of legalisation of EAS in that context (Battin, McLean, Bernheim, Deliens, Ganzini, Owens, Starks and Lewis (page 18)). However, the consultation document makes no mention of those academics and clinicians who gave evidence against legalisation. It is entirely one sided.

Q1. Which of the following best expresses your view of the proposed Bill?

1.3.2 It is true that in *Carter v Canada* the judges (both in the court of first instance and at the Supreme court) were more disposed to accept the interpretation of the evidence provided by those in favour. However, this is not a judgement that MSPs should receive uncritically. Indeed, the initial evaluation of the evidence by Justice Smith in *Carter*, far from being 'One of the most robust considerations of assisted dying legislation' (consultation document, page 18) was exposed as unreliable in *Fleming*. The Irish High Court judged her evaluation 'altogether too sanguine' and noted in contrast the 'strikingly high' level of 'assisted deaths' without explicit request in the Netherlands and Belgium, (*Fleming v Ireland & Ors* [2013] IEHC 2, <https://www.bailii.org/ie/cases/IEHC/2013/H2.html>, para 104). Neither *Carter v Canada* nor *Fleming v Ireland* concern Scottish law but insofar as they consider evidence relevant to the present consultation then the reasoning of both judgements should be considered and weighed carefully.

1.3.3 It may also be noted that the claim that 'legal safeguards, both substantive and procedural, in those jurisdictions have become enhanced, not eroded, over time' (consultation document, page 18) is in stark contrast to the experience of Canada, whose law was the occasion for this evidence. For that jurisdiction took less than five years to erode the key 'safeguard' of restricting 'medical assistance in dying' to those whose death was 'reasonably foreseeable'. There have also been legal developments in EAS in other jurisdictions over the same period. For example, in 2016 controversy was raised in the Netherlands over the euthanising of a woman with dementia who had to be restrained as they administered the lethal injection. In 2020 this case reached the Dutch Supreme Court which clarified that euthanasia of people with dementia (or with other conditions that affected competence to make decisions) was legal if there was a valid advance decision, even if the person no longer understood what was happening (see *Eva C.A. Asscher and Suzanne van de Vathorst*. 'Supreme Court rules on the first prosecution of a Dutch doctor since the euthanasia act' *BMJ Blog* Posted on April 28, 2020 <https://blogs.bmj.com/medical-ethics/2020/04/28/supreme-court-rules-on-the-first-prosecution-of-a-dutch-doctor-since-the-euthanasia-act-2/>).

1.3.4 Since the issue was last addressed by the Scottish Parliament in 2015, there have been more than 80,000 further deaths by euthanasia or assisted suicide worldwide, according to official reports. In every jurisdiction where these acts are legal there have been a significant increase in annual figures (Belgium 20%, Switzerland 22%, Washington 25%, Netherlands 26%, Oregon 85%, Luxembourg 213%, California 291%, Canada 646%). Canada, which has seen the highest rises, has now overtaken the Netherlands as having the highest number of deaths from euthanasia: 7,595 in 2020. (for links to the data for each jurisdiction see D.A. Jones 'Medically assisting suicide: Reviving a bad idea (paper)' *Politeia* <https://www.politeia.co.uk/medically-assisting-suicide-reviving-a-bad-idea-2/> footnote 12).

1.3.5 There seems to be a pattern that countries which have adopted the law more recently have expanded it more quickly, both in terms of numbers and in terms of changes in the law. Belgium quickly caught up with the Netherlands and Canada has since overtaken them both. Oregon waited more than 20 years before passing a minor amendment to relax the law in January 2020. Washington, after 12 years introduced much more extensive amendments (which have passed committee stage and floor votes but not yet passed into law), California, after 6 years introduced a set of amendments to relax the law, which have now passed into law and will come into effect January 2022. The expectation in the United States is thus that laws in this area will at some point be amended in the direction of eroding restrictions, expanding provisions, or limiting individual or institutional rights of conscience.

1.3.6 There has been much work published since the defeat of the Assisted Suicide (Scotland Bill) including research on the impact of EAS on assisted suicide and suicide rates (D.A. Jones and D. Paton 'How does legalization of physician assisted suicide affect rates of suicide?' *Southern Medical Journal* (2015) 108.10: 599-604), the first comprehensive study of the experience of Belgium (D.A. Jones, C. Gastmans and C. MacKellar (eds.) *Euthanasia and Assisted Suicide: Lessons from Belgium*, Cambridge: Cambridge University Press, 2017) in addition to revisions of existing works such as J. Keown, *Euthanasia, Ethics and Public Policy* Cambridge: Cambridge University Press, 2nd ed, 2018. Aware of the difficulties of summarising all this information, the Anscombe Bioethics Centre is publishing a series of short briefing papers on different aspects of the topic: [https://www.bioethics.org.uk/page/euthanasia\\_and\\_assisted\\_suicide\\_papers/default](https://www.bioethics.org.uk/page/euthanasia_and_assisted_suicide_papers/default) The Centre is also preparing an updated version of its 2015 guide to the evidence concerning EAS globally <http://www.bioethics.org.uk/evidenceguide.html> It is hoped that this will be launched early in the New Year.

Q2. 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.

2. The legislation is not required

2.0 The consultation document does not set out a list of aims of the Bill, but discusses a number of aims of which five may readily be identified (1) to resolve uncertainty in the law, (2) to prevent suicide among terminally ill patients, (3) to eliminate painful deaths (4) to offer greater protection than the current law, and (5) to allow greater choice than the current law. For each of these aims it is relevant to assess the extent of the need and to ask whether the proposed Bill would achieve its stated aim and/or whether alternative approaches might do so.

2.1 Uncertainty in the law

2.1.1 An important aim of this proposal is to provide 'legal certainty' and resolve the 'alarming lack of clarity' in the current law in Scotland on encouraging or assisting suicide and thus to ensure fulfilment of 'Scotland's international obligations under the European Convention on Human Rights' (consultation document page 9).

2.1.2 There is no law in Scotland that specifically prohibits encouraging or assisting suicide. That is to say, there is not equivalent to the Suicide Act 1961 (England and Wales), the Criminal Justice Act (Northern Ireland) 1966, the Criminal Law Act 1981 (Isle of Man),

Q2. 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.

the Homicide and Suicide (Bailiwick of Guernsey) Law 2006 and the Criminal Law (Suicide) Act 1993 (Republic of Ireland). Nevertheless, assisting suicide is illegal where the action has an immediate and causal relation to the death and where it constitutes culpable homicide or reckless conduct. Thus (unlike in other parts of the British Isles) it seems clear that the act of accompanying someone to Switzerland for the purpose of assisted suicide would not constitute an offence, whereas the act of procuring and distributing of lethal drugs to people who were suicidal may well constitute an offence.

2.1.3 The question of whether the current law is compatible with Scotland's international obligations under the European Convention on Human Rights is not an ethical or a political one but a legal one. Furthermore, while legal academics may offer opinions on the question, the determination of compatibility is ultimately a question for the courts. The law in Canada was changed because the Supreme Court declared the relevant sections of the Criminal Code to be incompatible with the constitution. The government was then required to enact legislation. In contrast, the law in England and Wales has been tested several times and has been declared compatible with the European Convention on Human Rights (in *R (Purdy) v DPP* [2009] UKHL 45 the DPP was required to provide explicit guidance on how the law was applied but the law itself was not challenged). Similarly, the Irish law has been tested and found compatible (*Fleming v Ireland & Ors* [2013] IEHC 2).

2.1.4 The consultation document takes as evidence for potential incompatibility a letter that appeared in the Herald Scotland. While this letter was signed by a number of legal academics it was a letter in a newspaper not an article in an academic journal subject to peer review and still less was it a legal judgement. It also appeared prior to a key legal judgement (*Ross v Lord Advocate* (2016) CSIH 12, cited in the consultation document footnote 17). In *Ross v Lord Advocate*, Lord Carloway and Lord Justice Clerk were clear that the current law is Convention compatible. It is a matter of agreement in European law 'that the margin of appreciation given to national authorities under the Convention extended to determining the question of whether or not assisted suicide should be lawful' (para 86). Furthermore, 'whether or not assisted suicide should be lawful, and in particular whether the risk to vulnerable people could be mitigated, was inherently a matter for Parliament rather than the courts' (ibid). While further legal clarity may be desirable, the judges also point out that 'It is important to recognise, however, that absolute certainty is impossible. Every legal concept and every legal rule will inevitably be surrounded by a penumbra of uncertainty.' (para 71)

2.1.5 It is for the Scottish Parliament to consider whether to maintain or to change the law in this area, just as they have considered this question before. In doing so MSPs are free to weigh the evidence of potential benefit and harm of any such change. There is no legal requirement to change the law and claims of incompatibility with the European Convention on Human Rights should be treated with scepticism until they are demonstrated in court.

2.1.6 It should also be noticed that, if there is supposed to be a problem with the current law caused by lack of clarity about when encouraging or assisting suicide is illegal, this problem would not be resolved by the proposed Bill. The proposed Bill would clarify that assisting suicide was legally permitted under certain specific conditions, but any and all actions that fall outside the Bill would be considered under the current law. It would remain uncertain, for example, whether assisting the suicide of someone who did not qualify under the terms of the Bill (for example, someone who was not terminally ill) was illegal, depending on the character of the assistance. It would remain uncertain whether encouragement of suicide was illegal. If the motivation for proposing the Bill was to clarify the law, then it should start by clearly defining an offense of encouraging and assisting suicide before carving out an exception to that offense. The present submission is not recommending that Scotland do this (i.e., that Scotland adopt the same legal approach as England and Wales, Northern Ireland, the Isle of Man, Guernsey and the Republic of Ireland); only to point out that concerns about clarity will not be addressed by clarifying an exception if one has not first clarified the rule to which it is an exception.

## 2.2 Preventing suicide among terminally ill people

2.2.1 There is a broad international consensus that 'every suicide is a tragedy' (World Health Organization. Preventing suicide: A global imperative. Geneva: World Health Organization, 2014, page 2) and thus that suicide prevention efforts should encompass all members of the community. It is therefore to be welcomed that the phenomenon of suicide among people living with terminal illness is coming to be recognised as a problem. It is also good that the consultation recognises the harm caused by suicide tourism (on this phenomenon see D. Sperling, *Suicide tourism: understanding the legal, philosophical, and socio-political dimensions*. Oxford: Oxford University Press, 2019). While accompanying someone to Switzerland for assisted suicide may not be a criminal offence in Scotland, it is a harmful practice that governments and responsible bodies should seek to discourage, for example by discouraging media reports that romanticise this activity or presents this as a noble or a heroic death (See T. Neuner, B. Hubner-Liebermann, G. Hajak & H. Hausner, 'Assisted suicide on TV-the public "license to kill"?' *European Journal of Public Health*, 19 (2009), 359-360).

2.2.2 Thus, unlike the issue of the uncertainty of the present law, which may or may not be a problem, the issue of suicide among people with terminal illness certainly is a problem. However, it is highly doubtful that a change in the law which would make assisted suicide accessible to more people, without the need to travel, would reduce the incidence of suicide (inclusive of assisted suicide). It may well be the case that some people feel consoled by the availability of assisted suicide and, paradoxically, the security that this gives to them enables some of the live. It may also be that having assisted suicide available locally may enable some people to delay the moment when they take their life. Nevertheless, in general, making a means of suicide more readily available is certain to increase the number of people who make use of those means. It is known from experience of suicide prevention that restricting the means of suicide reduces suicide rates (Marco Sarchiapone, Laura Mandelli, Miriam Iosue, Costanza Andrisano, and Alec Roy. 'Controlling access to suicide means.' *International journal of environmental research and public health* 8, no. 12 (2011): 4550-4562). This is confirmed by data from jurisdictions which have legalised assisted suicide. After legalisation the total number taking their life (either by assisted or non-assisted suicide) increases significantly. Analysis of data from the USA shows that this increase is significant even after applying various statistical tests for state effects, years effects, socio-demographic factors and state-specific linear trends (D.A. Jones and D. Paton 'How does legalization of physician assisted suicide affect rates of suicide?' *Southern Medical Journal* (2015) 108.10: 599-604). In Europe the mortality from euthanasia (in the Low Countries) or assisted suicide (in Switzerland) is much higher

Q2. 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.

than the rate of physician assisted suicide in the USA, and there is even less reason to believe that legalising physician assisted suicide or voluntary euthanasia reduces premature self initiated deaths.

2.2.3 It might be thought, however, that even if the total number of premature deaths increased, this would still be worthwhile if it were associated with a reduction of non-assisted suicides. If someone were to take their own life it would be much less traumatic from them and for their loved ones if they did this by assisted suicide rather than non-assisted suicide. However, there is no evidence that introducing euthanasia or physician assisted suicide leads to a net reduction in non-assisted suicide. In fact there is some evidence that non-assisted suicide also increases (though by most measures this is at a level that is not statistically significant). Why might non-assisted suicide increase? One reason might be through the normalisation of the assisted suicide (A. Kheriaty, 'Social Contagion Effects of Physician-Assisted Suicide: Commentary on "How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?"'. *Southern medical journal* 108, no. 10 (2015): 605-606). Another factor might be that those who seek assisted suicide but are not eligible might have an increased vulnerability to non-assisted suicide (See Elie Isenberg-Grzeda, Sally Bean, Carole Cohen, and Debbie Selby. 'Suicide attempt after determination of ineligibility for assisted death: A case series.' *Journal of pain and symptom management* 60, no. 1 (2020): 158-163 – note that this problem is not solved by changing the eligibility criteria, if there are any eligibility criteria some will not qualify).

2.2.4 Consider, as an illustration, a discussion of 100 consecutive cases of request for euthanasia for reasons of mental illness in Belgium (L. Thienpont et al. 'Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study'. *BMJ open*, (2015) 5(7), e007454). After five years, of 48 patients had their requests accepted, of whom 35 died by EAS (31 by lethal injection, 4 by oral self-administration), 2 died by non-assisted suicide and 11 postponed or cancelled the euthanasia procedure. Of this latter group, 8 stated that 'knowing they had the option to proceed with euthanasia gave them sufficient peace of mind to continue their lives' (Ibid, p. 5). Among the 52 patients whose requests were not accepted, 38 withdrew their requests, 8 were still continuing to pursue their request at the end of the study, 4 died by non-assisted suicide, one died from consequences of anorexia and one died 'after palliative sedation in a psychiatric hospital' (Ibid, p. 5) – a possible instance of sedation being used in Belgium as an alternative to euthanasia (S. Sterckx & K. Raus, 'The practice of continuous sedation at the end of life in Belgium: how does it compare to UK practice, and is it being used as a form of euthanasia?' in Jones, D.A., Gastmans, C & MacKellar (eds) *Euthanasia and assisted suicide: Lessons from Belgium*. Cambridge: Cambridge University Press, 2017, pp. 86-100). Note that these patients, who had an average age of 47, were not physically ill (other than, in one case, as a consequence of anorexia). They would not be covered by the proposals in the current consultation (which is for PAS for terminally ill adults). Nevertheless, these are examples of 'assisted dying' understood as an umbrella term and, like terminally ill individuals, these psychiatric patients constitute a population that is vulnerable to suicide.

2.2.5 In this study of 100 patients, it is clear that non-assisted suicides continued to feature despite the availability of 'assisted dying' (EAS). Indeed, a figure of 6 deaths by non-assisted suicide in a cohort of 100 over a 5-year period would be comparable with suicide rates in vulnerable populations with known suicidal ideation. It is also clear that the rate of intentional self-initiated death in this group of psychiatric patients (42 out of one hundred) is alarmingly high on any measure. This is not to deny that some people (8 in this group) felt more secure and more able to live because of the availability of a means to end their life. Rather, this study illustrates that the law affects people differently. It is an empirical question whether overall the presence of such laws helps reduce non-assisted suicide or not, and thus far there is no evidence from any jurisdiction that suggests that introducing 'assisted dying' (EAS) leads to reduction in rates of non-assisted suicide.

2.2.6 If changing the law to permit assisted suicide for the terminally ill will not help reduce non-assisted suicide, how is the problem of non-assisted suicide among people with terminal illness to be addressed? Part of the answer is palliative care, but there is no single or simple answer. What is needed is rather a consistent commitment to suicide prevention among the old as much among as the young, and among those living with terminal or chronic illness or disability as much as among those who are physically healthy. It involves a comprehensive vision that touches on a range of policies from disability benefits to positive and realistic portrayal of illness and disability in the media (D.A. Jones 'Assisted dying and suicide prevention' *Journal of Disability & Religion*, 22.3 (2018): 298-316).

### 2.3 Avoiding painful deaths

2.3.1 The need to address physical pain and other distressing symptoms at the end of life is also something that is an important aim. Too many people die bad deaths and this is a clear motivation of those who advocate physician assisted suicide or euthanasia. It is also clear that palliative medicine has not solved all problems.

2.3.2 It is less clear that the proposals in this law would address this problem. While there is certainly a need to fund research in this area, as in other areas of medicine, and to continue to seek new ways to address intractable symptoms, the great majority of cases of bad deaths are not because symptoms were uncontrollable but because they were uncontrolled. The first priority for end of life care, as with health and social care more generally, is to address inequalities in access and provision and to address issues of stigma against people who are older and people who live with disabilities. The estimate of how many people would have 'no relief from their pain as they die' in a situation where all problems of 'access to specialist palliative care' (page 13) have been solved is at best speculative and at worst a distraction from the much larger and more urgent problems of access.

2.3.3 It is clear from the reports into reasons for seeking assisted suicide in Oregon that the great majority do so because of concerns about autonomy, loss of dignity, and inability to engage in activities that make life enjoyable (See annual reports <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>). Less than a third cite 'inadequate pain control, or concern about it' as a contributory reason for seeking death, though this proportion citing pain or fear of pain has grown over the last twenty years from under 20% to over 30%, suggesting that fear of inadequate pain relief has increased gradually since the law was in force. It is unfortunate that reports do not distinguish between experience of pain and fear of future pain so it is not clear if this change represents a decrease in addressing symptoms or an increase

Q2. 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.

in the fear of them. Unfortunately there is no evidence for whether the level of pain or fear of pain has also increased among those who die in other ways in Oregon since the law came into force. More research is needed. Figures for the amount spent on palliative care are not a proxy for level of symptom relief achieved.

2.3.4 Another motivation that is increasingly cited in Oregon as a reason for seeking assisted death is fear of becoming a 'burden on family, friends/caregivers'. This is an example not of physical suffering but of existential suffering. The fact that this has increased over time seems to confirm the concerns raised by a number of disability activists that a change in the law would burden them further as they would have to justify their existence and the costs of their care. The oppressive effect of this idea is illustrated by a story related by the Australian bioethicist Nicholas Tonti-Filippini who died in 2014 and who suffered from a progressive and incurable illness: 'For several years, until I objected, I received from my health insurer a letter that tells me how much it costs the fund to maintain my health care. I dreaded receiving that letter and the psychological reasoning that would seem to have motivated it. Each year I was reminded how much of a burden I am to my community. The fear of being a burden is a major risk to the survival of those who are chronically ill.' (N. Tonti-Filippini, *About Bioethics*, Volume 2: Caring for people who are sick or dying. Ballan, VIC: Conor Court Publishing, 2012, page 112).

## 2.4 Greater protection

2.4.1 The consultation document argues that 'the current law in Scotland does not provide adequate protection to vulnerable people'. It gives, as examples, that 'a minority of cases are investigated when someone travels overseas for an assisted death', that 'decisions that doctors take that may hasten a person's death, such as withdrawing treatment or double effect, involve far fewer safeguards and less oversight than would be present under an assisted dying law. Where some doctors are currently acting illegally to directly end a person's life at their request (voluntary euthanasia), there are no safeguards in place at all' (consultation document, pages 16-17).

2.4.2 However, there is nothing in the proposed law that would increase the number of people investigated for travelling abroad for assisted suicide. Nor do the proposals involve any increase in the safeguards or oversight for common decisions such as withdrawal of treatment or double effect. If it is the case that current law and practice provide 'inadequate protection' then proposals are needed for how these safeguards could be increased. On this the consultation document is silent.

2.4.3 The document also points out that doctors end the lives of patients outside the law (by voluntary euthanasia). However, there is nothing in the document that would increase the protection of patients against such illegal actions. There is no suggestion of increased policing, prosecution or penalties against doctors for illegal euthanasia. At one point the document cites a newspaper article which describes research by Professor Clive Seale into end of life decisions in the United Kingdom. This research shows that such illegal actions do occur (footnote 85). However, the consultation document does not cite the report itself nor the follow up research done in 2009 (C. Seale, 'Counting end of life decisions'. *BMJ*. 2009 Sep 14;339) nor does it point out that unreported euthanasia and life ending without request also continue to occur in the Netherlands and Belgium, indeed at higher levels than in the United Kingdom (on Belgium see D.A. Jones 'Euthanasia and Assisted Suicide in Belgium: Bringing an End to Interminable Discussion' in D.A. Jones, C. MacKellar and C. Gastmans (eds) *Euthanasia and Assisted Suicide: Lessons from Belgium*. Cambridge: Cambridge University Press, 2017, pp. 235-257). Legal euthanasia does not of itself prevent illegal euthanasia. Furthermore, there is good evidence that sedation is used in Belgium as an alternative to euthanasia (used with the same intention but without the requirements of the euthanasia law) and that this is different not only in rationale but in practice and procedure from palliative sedation in the United Kingdom (see S. Sterckx & K. Raus, 'The practice of continuous sedation at the end of life in Belgium: how does it compare to UK practice, and is it being used as a form of euthanasia?' in Jones, D.A., Gastmans, C & MacKellar (eds) *Euthanasia and assisted suicide: Lessons from Belgium*. Cambridge: Cambridge University Press, 2017, pp. 86-100). Rather than improving patient safety, the normalisation of euthanasia in Belgium seems to have increased the openness of doctors to end life intentionally, sometimes with and sometimes without the request of the patient.

2.4.4 It might be said that while the document offers no improvement in relation to the practices it criticises, or protection against ongoing or increasing practices outside the law, it proposes legal provisions for a new practice which would offer some level of protection. This is true in that there is a higher level of bureaucracy required for these deaths, but experience in other jurisdictions is that failure to fulfil the procedural requirements rarely if ever leads to prosecution while the fact of legalisation has an effect on the culture. The protections offered by such requirements are weak whereas the impact on medical culture is strong.

## 2.5 More choice

2.5.1 A theme throughout the consultation document is that the proposed Bill would increase patient choice in relation to end of life care. It would provide 'more choice than the current law allows' (page 17). At one level this is unarguably true. Physician assisted suicide is not currently available as an organised practice within Scotland. If the Bill passed into law, then this would be an extra option. There may be other ways to increase choice at the end of life (for example more support for dying at home) but these will not satisfy those who seek the particular option of 'assisted dying' (EAS). Nevertheless, both medicine and law rightly limit choice when doing so serves the Common Good, for example, limiting access to antibiotics or regulations restricting movement and social contact so as to prevent transmission of COVID-19. The question is whether creating or restricting this or that choice is helpful or harmful for society as a whole. All laws constrain our choices to a greater or lesser extent.

2.5.2 Furthermore, laws of this kind have a very broad impact on society and on the practice of medicine. These changes in turn frame the choices that people have and the rational justifications they are able to give or are required to give. An important example, cited earlier, is the way that the availability of physician assisted suicide forces people to have to justify why they wish to live rather than save others the burden and expense of their care. They can avoid answering that question but the law invites the question and they do not have a choice about being placed in that situation where their death is a legal option. Giving an extra choice can therefore also

Q2. 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.

constrain autonomy in a potentially lethal way (X. Symons & R. Chu, "'Alive by default": An exploration of Velleman's unfair burdens argument against state sanctioned euthanasia.' Bioethics 34.3 (2020): 288-294.

Q3. Which of the following best expresses your view of the proposed process for assisted dying as set out at section 3.1 in the consultation document (Step 1 - Declaration, Step 2 - Reflection period, Step 3 - Prescribing/delivering)?

Fully opposed

**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.**

This response is strongly opposed to the legal provision of 'assisted dying'(PAS) and thus strongly opposed to process for 'assisted dying' as set out.

Q4. Which of the following best expresses your views of the safeguards proposed in section 1.1 of the consultation document?

Fully opposed

**Please explain the reasons for your response.**

This response is strongly opposed to the legal provision of 'assisted dying' (PAS) and regards the term 'safeguard' as misleading in the context of this Bill. The restrictions and procedures listed will not render the Bill safe to use. Even if the future practice were to remain within the bounds of the current Bill, the practice would facilitate suicide for certain categories of people, rather than seek to prevent it. It should also be noticed that in virtually all jurisdictions that have introduced some form of 'assisted dying' (EAS) the practice has expanded beyond what was initially proposed or envisaged.

Q5. Which of the following best expresses your view of a body being responsible for reporting and collecting data?

Partially supportive

**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.**

5.1 This response is strongly opposed to the legal provision of 'assisted dying' (PAS) and thus strongly opposed to reporting structures that are premised on this legal change. Furthermore, official oversight committees, where these review statements produced by self-reporting, and where a single committee is responsible for reviewing hundreds or thousands of reports, offer no real protection for patients. If reporting is viewed as a safeguard, it is spurious and thus dangerous because it gives the impression of security without delivering effective control.

5.2 Nevertheless, the collection of data can be helpful irrespective of the law. Indeed, there is an argument for setting up systems of data collection independent of legal oversight. The work of Clive Seale, already referred to, and the work of research groups in the Netherlands and in Flanders, offer possible models for data collection on a range of end of life decisions. These provide only a partial picture which is best augmented by encouraging quantitative and qualitative research by academic institutions. The model of a governmental mandate for a regular audit of end of life decisions is one that can be pursued irrespective of whether Scotland maintains its current laws or enacts legislation to permit PAS.

Q6. Please provide comment on how a conscientious objection (or other avenue to ensure voluntary participation by healthcare professionals) might best be facilitated.

6.1 From the 1960s to the turn of the millennium, conscientious objection within healthcare enjoyed very wide support as a means to enable people with different ethical viewpoints to practice medicine after permissive legislation had been passed. The archetypal example was abortion, and countries that liberalised their laws on abortion typically made provision for doctors and nurses to be able to practice medicine despite objecting to (elective) abortion. The reasons for objecting to abortion (as unjust to the unborn child and as contrary to medical ethics as understood in the Hippocratic tradition) was understood even if the law permitted abortion as a matter of individual liberty or harm reduction. However, in the twenty-first century attitudes have hardened and society has become less tolerant of objections to abortion. Conscientious objection is increasingly seen not as a reflection of diverse understandings of the good within a liberal society but as a political concession to individual sentiments which must not be permitted to impede the delivery of essential services. In some ways this marks a return to the view that the law exists to impose morality, it is just that the morality that is imposed is different.

6.2 Within the current political and social context conscientious objection provisions tend to be interpreted minimally and arguably this has also influenced judicial thinking, especially in England (contrast the Scottish Court of Session [2013] CSIH 36 and the English Supreme Court[2014] UKSC 68 in case of Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland)). Where permissive legislation is passed that would enable actions that many clinicians, in good conscience, would regard as harmful, unethical and unjust, as many would regard assisted suicide and euthanasia, any conscience provision needs to be as explicit as possible in what roles and actions it protects. The law also needs to include protection for institutions.

6.3 Nevertheless, even if robust conscience provisions were enacted it would be naïve to believe that they would offer protection to health and social care professionals in the longer term or even medium term. The experience of other countries, and especially of Canada, is that, physicians are already required by law to facilitate euthanasia or assisted suicide and that hospices that object to facilitating such practices have all state funding removed.

## Financial Implications

Q7. 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 reduction in costs

**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.**

7.1 This Bill would likely reduce financial costs significantly as facilitating someone's death will cost less than their ongoing health and social care, plus the cost of the state pension and any other benefits they receive. On the other hand, if the person has independent means (property, investments, private pension) then this spending, whether on social care or on daily living, contributes to the local economy and to tax revenue (VAT, Council Tax, television licence etc.).

7.2 If those who end their lives early are among the wealthier members of society with private means (which seems to be the pattern in Oregon and Canada) then the effect of the law will be that more income will be inherited and less spent while alive, inheritance tax notwithstanding. This may negate to some extent the saving of reduced NHS costs. However, if more of those who are in receipt of benefits and have no private income or capital accept the option of assisted suicide, this will lead to significant cost savings both to local and national government and to the NHS. These savings will be in direct proportion to the length by which life is shortened.

7.3 It is possible that occasional abuses might lead to court cases which are costly, but the experience of other jurisdictions is that very few abuses are prosecuted in court.

## Equalities

Q8. 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?

Negative

**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.**

#### 8.1 Protected characteristics of age and disability

8.1.1 These categories may be taken together as it is clear that there are a disproportionate number of older people and a disproportionate number of disabled people, among those who would be eligible for assisted suicide under the provisions of this Bill. Whether this is regarded as a positive or negative impact will depend on how one regards the practice of assisted suicide, whether as the avoidable and premature taking of life or as an option that is beneficial for some people. Nevertheless, even those who regard it as beneficial for some recognise that it can be open to abuse not least the abuse of coercion or manipulation. Hence, at the very least, a disproportionate number of older and disabled people will face the danger of a new kind of abuse.

8.1.2 The consultation document points out that disabled people are diverse in their beliefs and it is wrong to speak of the disabled perspective on assisted suicide, or indeed on anything else. Nevertheless, it is clear that at least some disabled people feel threatened by this legislation and do so precisely on account of their disability. It is also noteworthy that while only a few organisations are officially opposed to a change in the law in this area, no organisations representing disabled people is in favour of a change in the law. In the House of Lords debate there were contributions from disabled people for and against the Bill this submission would commend the contributions of Baroness Jane Campbell and Baroness Tanni Grey-Thompson as eloquent expressions of an important argument against legalisation.

#### 8.2 Protected characteristic of gender reassignment

8.2.1 There are no data to evaluate whether legalisation of euthanasia or assisted suicide has an impact on non-assisted suicide rates among those of diverse gender identity (as this is a population with a high suicide risk). However, it is notable that both in the Netherlands and in Belgium a small number of individuals have been provided with euthanasia or assisted suicide because of gender dysphoria. Thus, in at least a handful of cases gender reassignment has been given as a reason not to protect someone from suicide but to facilitate suicide or to end their life on their request.

8.2.2 Assisted suicide or euthanasia for reasons of gender dysphoria would not be within the scope of the proposed Scottish Bill, but the consultation document uses 'assisted dying' as an umbrella term and considers evidence from the Netherlands and Belgium as to the impact of 'assisted dying' considered broadly. It should be acknowledged explicitly that to encourage or assist suicide on the basis that someone has sought gender reassignment is direct and lethal discrimination against someone with a protected characteristic and the Scottish Parliament should condemn such actions unequivocally.

#### 8.3 Protected characteristic of religion or belief

8.3.1 The major impact of the proposed legislation on religion or belief will be on healthcare professionals and carers who, for ethical reasons embedded in or expressed as aspects of their religion or belief object to encouraging or assisting suicide. It is of course the case that many people who are not religious are also opposed to encouraging or assisting suicide, and some people who are religious are in favour of these practices. Nevertheless, there will be at least some people whose objection is expressed in religious terms or is expressive of their religious identity. There will also be religious institutions that provide health or social care and which wish to maintain their ethos for the sake of those who wish to work in or to receive care of with this characteristic. The negative impact on these individuals and institutions will depend on the extent to which robust provisions are made for the consciences of individuals and the ethos of institutions. See above in relation to conscientious objection for reasons to think that it will be difficult to mitigate this negative impact.

#### 8.4 Protected characteristics of sex

8.4.1 There is considerable evidence that the practices of assisted suicide and euthanasia have a disproportionate effect on women. The details vary between different jurisdictions but in general women are more resilient than men in relation to suicide but are equally or more vulnerable to assisted suicide. Thus, while roughly equal numbers of men and women die by assisted suicide in Oregon, for men these represent only 20% of total suicide (inclusive of assisted suicide) whereas for older women more than half (53%) of total suicide is assisted suicide. At the same time, since legalisation of physician assisted suicide the rate of non-assisted suicide among men fell by 10.9% (due to falls in suicide by firearm) but rose by 56.4% among older women. As a result, the rate of total suicide (inclusive of assisted suicide) in those over 65 in Oregon between 1998 and 2018 increased by 23.3% in older men but by 190.2% in older women. (Figures derived from S.S. Canetto & J.L. McIntosh, 'A Comparison of Physician-Assisted/Death-With-Dignity-Act Death and Suicide Patterns in Older Adult Women and Men'. The American Journal of

Q8. 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?

Geriatric Psychiatry, (2021) S1064748121003559)

8.4.2 As similar pattern is found in Switzerland where a national cohort study in 2015 found that: 'In the present study the substantial increase in assisted suicide in older women, with a net increase in the rate of suicide overall [inclusive of assisted suicide] in women, must be of concern. We have argued previously that further research is needed to clarify the reasons for the tripling of rates in assisted suicides in women, and the doubling of rates in men, and to what extent this difference might reflect greater vulnerability of women compared with men' (N. Steck, M. Zwahlen & M. Egger, 'Time-trends in assisted and unassisted suicides completed with different methods: Swiss National Cohort'. Swiss Med Wkly. 2015;145:w14153, page 5).

8.4.3 On this basis Canetto and McIntosh conclude that: 'In jurisdictions where assisted suicide/MAID is legal and where assisted suicide/MAID and unassisted-suicide comparative studies have been conducted (i.e., Switzerland and Oregon), older adult women's likelihood of self-initiated death has grown substantially since MAID legalization.' (S.S. Canetto & J.L. McIntosh, page 8).

8.4.4 Consideration of non-assisted suicide rates and rates of self-initiated death in the Low Countries in comparison to France and Germany and in Switzerland in comparison to Austria also shows more negative impact on women. In Luxembourg non-assisted suicide rates were dropping until 2009 when the euthanasia law was introduced, and since then have been flat, but rates of non-assisted suicide in women have risen. In Belgium the non-assisted suicide rate has fallen since euthanasia was legalised in 2002, but it has not fallen as quickly as other European countries, especially among women. Belgium now has the sixth highest rate of non-assisted suicide in Europe among men, exceeded only by the former communist countries Estonia, Hungary, Slovenia, Latvia and Lithuania, but the non-assisted suicide rate among women is the highest in Europe (See OECD Data: Suicide Rates <https://data.oecd.org/healthstat/suicide-rates.htm> it is possible to specify countries, total/male/female, and most recent or historic data and it is possible to set a background, one option being the European Union).

8.4.5 In Switzerland non-assisted suicide rates have fallen among men and women and have followed a very similar pattern to non-assisted suicide rates in Austria. However, since 1998, when Dignitas was founded, suicide inclusive of assisted suicide (which is how suicide rates in Switzerland were reported until 2009) have risen in relation to Austria, and since 2010 have risen in real terms. However, the rise among women has been much sharper. Among men between 2010 and 2017, the suicide rate inclusive of assisted suicide rose from 22.0 to 26.5 but this is not yet at the level that it was in 1998 (30.2). Among women the suicide rate inclusive of assisted suicide rose consistently from 2000 and between 1998 and 2017 it almost doubled (from 9.4 to 18.6) (Figures derived by combining OECD Data with data on assisted and non-assisted suicide collated by Dignitas <http://www.dignitas.ch/images/stories/pdf/statistik-suizid-ftb-bevoelkerung-lebenserwartung-ch-e.pdf> for further analysis see D.A. Jones 'Euthanasia, assisted suicide and suicide rates in Europe: A reply to Lowe and Downie', Journal of the Ethics of Mental Health, forthcoming)

## Sustainability

Q9. 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?

No

Q9. 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?

**Please explain the reasons for your response.**

This Bill does not embody the principles of sustainable development in that it is not justified on the basis of strong scientific evidence.

## General

Q10. 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 Centre would be happy to provide clarification on this submission and/or further written or oral evidence as requested.