THE SOCIETY FOR THE PROTECTION OF UNBORN CHILDREN

Submission to the Consultation on the Assisted Dying for Terminally Ill Adults (Scotland) Bill

The Society for the Protection of Unborn Children (SPUC) is a human rights group established in 1966 and since then has been active in the field of public campaigning, debate and lobbying in relation to life issues including euthanasia. Its aims include, *inter alia*, the following:

- To affirm, to defend and promote the existence and value of human life from the moment of conception until its natural end.
- To examine existing or proposed legislation, regulations or public policies relating to the protection of human life and the promotion of human dignity and to support or oppose such as appropriate.

In furthering these aims, SPUC has been involved in major litigation surrounding abortion, freedom of conscience and the right to life of vulnerable individuals over several years.

SPUC espouses the philosophical tradition that recognises the inviolability of human life and the prohibition on doctors taking the life of their patients set out by the Hippocratic Oath (*c*. 400-350 BC) when it states:

> "I will neither give a deadly drug to anybody if asked for it nor will I make a suggestion to this effect. Similarly, I will not give to a woman an abortive remedy."[1]

This tradition was reaffirmed in 1948 by the Universal Declaration on Human Rights, the International Code of Medical Ethics adopted by the World Medical Assembly and the Declaration of Geneva which bound doctors to "maintain the utmost respect for human life from the time of conception, even under threat," and not to use their medical knowledge "contrary to the laws of humanity."[2]

Considering the 2,500-year tradition in medical ethics that the Assisted Dying for Terminally Ill Adults (Scotland) Bill seeks to overturn and the radical cultural change that would result from its enactment, SPUC urges the sponsor(s) of the Bill to:

1. withdraw this proposed legislation and;
2. promote measures that genuinely address the current shortcomings in end-of-life care that propel some individuals to take the desperate step of seeking to end their own lives.

[1] Ludwig Edelstein, *Ancient Medicine: Selected Papers of Ludwig Edelstein,* (eds, O Temkin and C Lilian Temkin, trans from German, C Lilian Temkin, John Hopkins Press, 1967) 6

[2] International Code of Medical Ethics, Duties of Doctors to the Sick: *A doctor must always bear in mind the importance of preserving human life from the time of conception until death"* 1948

Executive Summary

1. The legalisation of assisted suicide creates additional pressure on the vulnerable. In Oregon in 2020, a majority of people killed by assisted suicide listed concerns about being a "burden on family, friends/caregivers" as a reason to end their lives. A recent report found that more than a third of older people in Scotland feel that they are a burden to society.

2. Disabled people fear assisted suicide. Its legalisation risks reinforcing negative stereotypes of disability adding to the difficulties faced by disabled people.

3. Assisted suicide cannot be controlled. In several countries assisted suicide has been used to introduce euthanasia. Vulnerable groups, including children, infants, dementia patients, psychiatric patients, those who are not dying, and those who have not requested death are then vulnerable to euthanasia.

4. The majority of doctors in the UK do not support assisted dying. This opposition is strongest amongst doctors who work most closely with dying patients.

5. Evidence suggests that in countries with assisted suicide there is a rise in suicide more generally.

6. No safeguard can be considered capable of preventing abuses since assisted suicide by nature is an abuse of medical ethics and human rights. It is not a medical procedure but acts contrary to the goals of medicine, namely to cure and care but not to harm or kill patients.

7. The proponents of the Assisted Dying for Terminally Ill Adults (Scotland) Bill have failed to demonstrate that the current legal framework is unclear, ineffectual or excessively rigid. Nor have they shown that their proposals are capable of overcoming the dangers and negative consequences inherent in assisted suicide.

For all these reasons, the legislation should be withdrawn and measures that genuinely address the current shortcomings in end-of-life care should be promoted instead.

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

Fully Opposed:

1.1 The legalisation of assisted suicide creates additional pressure for the vulnerable.
When the frail, the ill or the elderly are told that they can end their lives if they choose to do so, it conveys a perception that they might be better off dead. Even if this impression is unintentional, it generates pressure for them to choose death. Where assisted suicide has been legalised, a major reason cited by people who choose to end their lives prematurely is the feeling that they are a burden on others.

- In Oregon in 2020, a majority (53.1%) of people killed by assisted suicide cited a fear of being a "burden on family, friends/caregivers" as a reason to end their lives.[3]
- In Washington State in 2018, 51% of people who were killed by assisted suicide said that being a burden on family, friends and caregivers was a reason to end their lives.[4]

In one study researchers also identified a range of pressures on vulnerable people who desire assisted suicide, leading to a choice "strongly influenced by fears, sadness and loneliness". The same researchers were concerned about the development of a culture that would "increase social pressure on older people and reinforce negative ideas surrounding old age".[5]

[3] Oregon Death with Dignity Act 2020 Data Summary
[4] 2018 Death with Dignity Act Report (July 2019)
[5] E van Wijngaarden *et al* (2017) Assisted dying for healthy older people: a step too far? *BMJ* 357:2298

It is estimated that between 7% and 9% of older people in Scotland are victims of at least one form of abuse, with over 40% of victims suffering more than one kind of abuse.[6] A recent report found that more than a third of older people in Scotland feel that they are a burden to society, while 34% felt life was getting worse for older people.[7] In such an atmosphere, older people are vulnerable to perceived pressure to end their lives prematurely.

1.2 Disabled people fear assisted suicide.

People with disabilities particularly fear a change in the law which could result in them being pressured to end their lives. Speaking about the Assisted Dying Bill in the House of Lords on 22 October 2021, Baroness Grey-Thompson addressed this point stating:

> "Many people have also said to me, 'If my life was like yours, I would kill myself.' I have a huge amount of privilege in my life, but if people think this, it becomes very easy for them to conflate disability and a six-month diagnosis, and decide that we have no right to live."[8]

Proponents of "assisted dying" insist that it is not about disability. However, while people with disabilities are not usually terminally ill, the terminally ill are almost always disabled.[9] Although intractable pain is often emphasised as the primary reason for enacting assisted suicide legislation, the top five reasons doctors in Oregon report for issuing lethal prescriptions are:

- "loss of autonomy" (91%)
- "less able to engage in activities" (89%)
- "loss of dignity" (81%)
- "loss of control of bodily functions" (50%)
- "feelings of being a burden" (40%)[10]

These situations are commonly experienced by disabled people and the impact that a change in the law would have on them cannot be dismissed simply by insisting that the Bill is not about the disabled.

Baroness Grey-Thompson DBE argued that "it is fundamentally wrong to have assisted dying on the NHS when there is no right to palliative care."[11] Our response to failures in health care provision should be to offer practical help and human empathy, not to make disabled people feel they ought to choose death. The establishment of assisted suicide as public policy will reinforce negative stereotypes of disability and the social conditions that add to the difficulties faced by disabled people.[12]

1.3 Assisted suicide cannot be controlled.

The arguments used for assisted suicide are essentially the same as for euthanasia, and experience demonstrates that they are gradually used to apply pressure for euthanasia. In countries where assisted suicide and euthanasia are both legal, over time vulnerable groups, including children, infants, dementia patients, psychiatric patients, those who are not dying, and those who have not requested it are euthanised. In Dutch and Belgian reports up until 2010, between 7% and 9% of all infant deaths involved active euthanasia, that is, a lethal injection. More recent reports almost certainly underestimate the rate

[6] Age Concern Scotland, "Elder Abuse," https://www.ageconcernscotland.org.uk/elder-abuse/
[7] Age Scotland, The Big Survey 2021, https://www.ageuk.org.uk/globalassets/age-scotland/documents/policy-and-research/high-4967-scotinfrom-age-scotland-big-survey---full-report.pdf [accessed 11 October 2021]
[8] Assisted Dying Bill [HL] Second Reading, *Hansard*, 22 October 2021 https://hansard.parliament.uk/Lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL)#contribution-ADCCABCD-B4E6-414B-8EBE-175C9C21735E
[9] Not Dead Yet, *Disability Rights Toolkit for Advocacy Against Legalization of Assisted Suicide.* https://notdeadyet.org/disability-rights-toolkit-for-advocacy-against-legalization-of-assisted-suicide
[10] Oregon Death with Dignity Act 2020 Data Summary
[11] Assisted Dying Bill [HL] Second Reading, *Hansard*, 22 October 2021
[12] CJ Gill, "No, we don't think our doctors are out to get us: Responding to the straw man distortions of disability rights arguments against assisted suicide." (2010) *Disability & Health J* 3:31-38.

because practitioners fail to report cases, some of which they considered not to be euthanasia even though a lethal injection was used.[13] In the Netherlands the number of people with dementia killed by euthanasia has risen steadily from 12 cases in 2009 to 162 in 2019.[14]

Advocates of "assisted dying" often claim that "there have been no cases of abuse in Oregon's law". However, the State does not collect adequate data to justify such claims. Data on assisted deaths in Oregon come from a form filled out by the physician *who wrote the lethal prescription*. And in the first decade of legalisation, one quarter (62,271) of all lethal prescriptions were provided by just three doctors.[15] Also, the number of cases of assisted suicide in Oregon has steadily increased annually from 16 in 1998 to 188 in 2019, an increase of 1175%.[16] Since legalised assisted suicide is shielded by doctor-patient confidentiality "in effect, any physician-assisted suicide regulation must, in the end, be physician self-regulated."[17]

1.4 Assisted suicide is not the answer to pain.
Intractable pain is not among the reasons most commonly cited in requests for assisted suicide, and suicide is not the solution to pain. Good palliative care should ensure that pain is controlled. Research suggests that palliative care can significantly improve quality of life, with people experiencing fewer physical symptoms[18] and reduced rates of depression.[19] Legalising assisted suicide, however, risks reducing the provision of palliative care. In Belgium, hospitals and nursing homes reluctant to practise euthanasia or assisted suicide have been "pilloried and threatened with losing their public funding".[20] In Canada, public funding was withdrawn from several hospices that refused to participate.[21]

1.5 Doctors oppose assisted suicide.
Doctors have historically been opposed to both euthanasia and assisted suicide. The majority of doctors in the UK do not support assisted suicide. This opposition is strongest amongst doctors who work most closely with dying patients and are most familiar with treatments available. When last polled, 82% of members of the Association for Palliative Medicine of Great Britain & Ireland rejected the legalisation

[13] Gregory K Pike, *Euthanasia and Assisted Suicide – When Choice is an Illusion and Informed Consent Fails*, 2020 https://bioscentre.org/articles/euthanasia-and-assisted-suicide-when-choice-is-an-illusion-and-informed-consent-fails/
[14] Regional Euthanasia Review Committees RTE Annual Report 2019 https://english.euthanasiecommissie.nl/the-committees/documents/ publications/annual-reports/2002/annual-reports/annual-reports
[15] Katherine Sleeman, "Assisted dying—how safe is safe enough?" 8 March 2018, *the bmj opinion* https://blogs.bmj.com/bmj/2018 Accessed 4 November 2021
[16] Oregon Health Authority, Public Health Division (2020) Oregon Death with Dignity Act: 2019 Data Summary. See https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf Accessed 2 April 2020
[17] Daniel Callahan and Margot White, 'The Legalisation of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village' (1996) 30 *Uni Richmond Law Rev.* 1
[18] IJ Higginson, C Bausewein, CC Reilly, W Gao, M Gysels, M Dzingina, P McCrone, S Booth, CJ Jolley, J Moxham "An integrated palliative and respiratory care service for patients with advanced disease and refractory breathlessness: a randomised controlled trial." *Lancet Respir Med*. (2014) 2 (12) 979-87 doi: 10.1016/S2213-2600(14)70226-7. Epub 2014 Oct 29. PMID: 25465642.
[19] Jennifer Temel, Joseph Greer, Alona Muzikansky, Emily Gallagher, Sonal Admane, Vicki Jackson, Constance Dahlin, Craig Blinderman, Juliet Jacobsen, William Pirl, John Billings, & Thomas Lynch, "Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer" (2010) *New Eng J Med*, 363. 733-42 https://www.nejm.org/doi/pdf/10.1056/NEJMoa1000678
[20] D A Jones, ed *Euthanasia and Assisted Suicide: Lessons from Belgium* (CUP, 2017) 40
[21] L Harding 'Delta Hospice Society envisions new private MAiD free facility.' *Western Standard*, 18 July 2021: https://westernstandardonline.com/2021/07/delta-hospice-society-envisions-new-private-maid-free-facility/

of assisted suicide[22] and the Royal College of General Practitioners (RCGP)[23] and the British Geriatrics Society[24] remain opposed.

The American Medical Association believes that: "[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."[25]

Similarly, the World Medical Association Declaration of Venice on Terminal Illness states:

> "When addressing the ethical issues associated with end-of-life care, questions regarding euthanasia and physician-assisted suicide inevitably arise. The World Medical Association condemns as unethical both euthanasia and physician-assisted suicide."[26]

1.6 Suicide rates go up.
Evidence suggests that in countries with assisted suicide there is a rise in suicide more generally. A 2015 study looking at the United States found that making it legal for doctors to assist someone to end their life was linked to a 6.3% increase in total suicides and a 14.5% increase for those over 65 years of age.[27] The authors of the report concluded that changing the law was associated with "an increased inclination to suicide in others". This implies that the change in the legal status of assisted suicide had engendered a cultural change. Suicide in those US states that legalised it now seems to be regarded as more acceptable.

Suicide is rightly seen as a profound tragedy and society attempts to help those at risk of suicide see their lives as worth living. Legalising assisted suicide undermines community efforts to combat suicide more generally. It also risks abandoning the weak and vulnerable at precisely the time they are in most need of support.

The Scottish Government's webpage on suicide prevention states: "The Scottish Government believes that no death by suicide should be regarded as either acceptable or inevitable." It is impossible to reconcile this Bill with this aim. It is also difficult to see how doctors could reconcile their efforts to prevent suicide in some patients while advising others on how to kill themselves.

Legalising assisted suicide means that some people who say they want to die will receive suicide intervention, while others will receive suicide assistance. The difference between these two groups of people will be their health or disability status, leading to a two-tiered system that results in death for the socially devalued group.[28]

1.7 Legalising assisted suicide does not necessarily result in greater patient autonomy**.**

---

[22] Association for Palliative Medicine of Great Britain & Ireland Physician Assisted Dying Web Materials, "The Association for Palliative Medicine (APM) Web Materials On Actively and Intentionally Ending Life (Variously Called 'Assisted Suicide', 'Assisted Dying, 'Aid In Dying' And 'Euthanasia')" Polling on the Opinion of Doctors https://apmonline.org/news-events/apm-physician-assisted-dying-web-materials/
[23] Royal College of General Practitioners, "Assisted Dying, RCGP's 2020 decision," https://www.rcgp.org.uk/policy/rcgp-policy-areas/assisted-dying.aspx
[24] British Geriatrics Society, "Physician Assisted Suicide," 10 July 2015, https://www.bgs.org.uk/policy-and-media/physician-assisted-suicide
[25] AMA *Code of Medical Ethics Opinion 5.7.* https://www.ama-assn.org/delivering-care/ethics/physician-assisted-suicide
[26] WMA Declaration of Venice on Terminal Illness WMA General Assembly, Pilanesberg, South Africa, October 2006, *Handbook of WMA Policies* D-1983-01-2006
[27] DA Jones, D Paton, "How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?" (2015) *South Med J,* 108 (10) 599-604 doi: 10.14423/SMJ.0000000000000349. PMID: 26437189
[28] D Coleman "Not Dead Yet" in K Foley & H Hendin, eds *The Case against Assisted Suicide. For the Right to End-of-Life Care,* (John Hopkins University Press, 2002) 221.

Evidence indicates that patient autonomy is too susceptible to external influences to provide robust protection for vulnerable groups such as the elderly, infirm or disabled. In the Netherlands the trajectory from assisted suicide and voluntary euthanasia towards non-voluntary euthanasia (see 1.3 above) has meant that personal autonomy is not a decisive factor for many Dutch physicians.

> "This is supported by the finding that 1000 people actually had their lives terminated without an explicit request. In many cases, it is the condition of the patient, not the request, which is the real ground for euthanasia…"[29]

This has been the experience of the Netherlands.

> "Paradoxically, the jurisprudential 'legality' of euthanasia that was fought for by advocates of voluntary euthanasia on the basis of the principle of autonomy and self-determination of patients, actually has increased the paternalistic power of the medical profession above its last limit, above the law."[30]

Question 2. Do you think legislation is required, or are there are other ways in which the Bill's aims could be achieved more effectively?

Legislation is not required and the attempt to change the law should be abandoned as unethical and dangerous.

2.1 Legislation is not required. The criticisms of the current legal framework presented in the consultation document are manifestly ill-founded. The law is neither unclear, ineffectual nor excessively rigid. The authors of the Bill have failed to demonstrate any need for new legislation. The real objection to the current legal arrangement appears to be its chilling effect on the medical profession. Without a guaranteed legal defence for doctors who provide lethal substances to their patients, it is extremely unlikely that routine access to assisted suicide or euthanasia could be introduced to Scotland.

2.2 The intent of the Bill is, to authorise doctors to supply lethal drugs to gravely ill patients for the purpose of committing suicide. As mentioned above, this goes against the profound insights of more than 2,000 years of medical ethics. Its effects are also potentially very dangerous. In jurisdictions where assisted suicide has been legalised, it has:

i) relativised the right to life by creating a category of individual with a reduced level of legal protection;
ii) precipitated a slide towards non-voluntary euthanasia;
iii) helped to normalise suicide more generally and;
iv) has damaged the relationship between patients and the medical profession.

The Bill seeks to legitimise a practice that should not be contemplated in a civilised society. If enacted it would cross a Rubicon that would permanently damage the culture of medicine and health care in Scotland and the wider UK and most importantly, have a detrimental effect on how vulnerable individuals (including the disabled) are perceived and treated.

2.3 Far from lacking oversight, current Scottish law offers a far greater level of protection than that provided in any assisted suicide legislation enacted to date. At present, anyone who assists another person to commit suicide will know that manipulative behaviour or criminal motivation could be uncovered by an investigation. The Bill, however, offers no significant deterrent for someone seeking to exert an improper influence over a vulnerable person.

---

[29] Mike Brogden, *Geronticide: Killing the Elderly (*Jessica Kingsley, 2001) 170

[30] Jos M Welie, 'The Medical Exception: Physicians, Euthanasia and the Dutch Criminal Law' (1992) 17 *J Med & Phil* 419, 435

2.4 Ensuring that people do not suffer "a prolonged and painful death" (one of the claims made for the Bill) is no reason to legalise assisted suicide. Uncontrollable pain does not even rank in the top five reasons that people in Oregon give for choosing assisted suicide.[31] Assisted suicide is no better a solution to physical pain than to psychological suffering. Good palliative care should ensure that physical pain is controlled well. Research suggests that palliative care can significantly improve quality of life with people experiencing fewer physical symptoms[32] and reduced rates of depression.[33]

2.5 There is also little evidence that an assisted death is quick and painless. Experts writing in the British Medical Journal point out that: "The safety and efficacy of previous and current oral assisted dying drug combinations is not known" and that reported adverse effects of drug combinations used to induce death "include vomiting, myoclonus and a prolonged dying process of up to 47 hours."[34] Dr Joel Zivot, an associate professor of anaesthesiology and surgery and an expert witness writes: "I am quite certain that assisted suicide is not painless or peaceful or dignified. In fact, in the majority of cases, it is a very painful death."[35]

2.6 One of the claims made for the Bill seems to be that it would reduce unassisted suicide. The presentation of physician-assisted suicide (PAS) as a means of suicide prevention is irrational, implausible and unsupported by the evidence. It is self-contradictory to advance legislation that actively facilitates, and therefore encourages, assisted suicide on the pretext that it will prevent instances of suicide. It may be that some would choose PAS who might otherwise die by unassisted suicide but as PAS involves the "normalisation" of the idea of suicide, it makes both PAS and unassisted suicide more readily imaginable. Evidence from North America suggests that *legalising PAS leads to a significant increase in the number of those who chose to die* (by PAS or by unassisted suicide) and *does not reduce unassisted suicide*. Indeed, there is evidence that rates of unassisted suicide also increase.[36] The aim of reducing suicide would be better achieved by ensuring all necessary support, including sufficient palliative care, is made routinely available to those with a terminal illness so that no one feels that suicide is the solution.

2.7 Advocates of legalisation argue that it would reduce the incidence of people dying by assisted suicide/euthanasia in other jurisdictions. It seems likely that if the Bill were passed then most people would prefer PAS in Scotland to assisted suicide in Switzerland, but the overall number of people who die by PAS/AS would likely increase and thus more people would end their lives prematurely. Arguments based on Dignitas being 'overburdened' seem to be simply manipulative. Dignitas may be overburdened because it provides assisted suicide to individuals who do not have serious health issues. One elderly woman who was helped by Dignitas to end her life said she was lonely and disliked her appearance in old age.[37] The accusation of Scotland outsourcing its problem is commonly made in any debate involving a controversial practice. The legal policies and cultural influences of other nations ought to have no bearing on what a country, such as Scotland, with its own traditions, values and culture decides to do.

---

[31] Oregon Death with Dignity Act 2018 Data Summary

[32] Irene J Higginson, et al, "An integrated palliative and respiratory care service for patients with advanced disease and refractory breathlessness: a randomised controlled trial," *The Lancet Respiratory Medicine*, 2, 12, 979 - 987

[33] Jennifer Temel, Joseph Greer et al, "Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer", *New Eng J Med*, http://www.nejm.org/doi/pdf/10.1056/NEJMoa1000678

[34] "The impact on general practice of prescribing assisted dying drugs", *BJGP Life*, 28 September 2021, https://bjgplife.com/2021/09/28/the-impact-on-general-practice-of-prescribing-assisted-dying-drugs/

[35] Joel Zivor, "Last rights: assisted suicide is neither painless nor dignified", *The Spectator*, 18 September 2021 https://www.spectator.co.uk/article/last-rights-assisted-suicide-is-neither-painless-nor-dignified

[36] D Paton, and DA Jones, "How does legalization of physician assisted suicide affect rates of suicide?" (2015) *Southern Medical Journal* 108.10, 599-604.

[37] Ole Hartling, *Euthanasia and the Ethics of a Doctor's Decisions: An argument against dying.* (trans Tim Davis, Bloomsbury, 2021) 137-8

2.8 The sponsor of the Bill claims that this "proposal complements excellent palliative care" and "co-exists with support for more and better palliative care". This is difficult to reconcile with the fact that the majority of physicians involved in palliative care oppose assisted dying. A poll commissioned by the British Medical Association in 2020 found that 76% of palliative care physicians opposed a change in the law.[38] In a 2019 survey published by the Royal College of Physicians (RCP), only 9% of palliative care physicians supported the legalisation of assisted suicide.[39] This suggests that if assisted suicide was legalised, most physicians who care for terminally ill patients would not be willing to participate in the practice. Based on the survey conducted by the RCP, only 24% of doctors are willing to prescribe lethal medication. Only 18% of doctors in geriatric medicine, 24% in medical oncology and 5% in palliative care stated that they would be willing to participate.[40] The aim of having excellent palliative care in Scotland cannot be achieved by ignoring the objections of those who specialise in this branch of medicine. As stated above (see 1.4) legalisation of assisted suicide has had a negative impact on the practice of palliative care in Belgium and Canada.

Question 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 opposed:

3.1 Assisted suicide is unethical and dangerous. Once the law has been changed, no process or protocol would be capable of providing vulnerable individuals with the level of protection from coercion that currently exists. Speaking in the House of Lords on 22 October 2021, Lord Herbert of South Downs argued that legislating to permit the taking of a patient's life crossed the Rubicon and warned that it would introduce "the idea that a patient's life may be taken, albeit with their consent." He stated:

> "Life, in some circumstances, is no longer to be protected by an inviolate principle, but rather by administrative safeguards and term limits. The fear is not only that those safeguards may prove inadequate, that vulnerable people may be exploited and encouraged to end their lives and that, in reality, choice over death has been given to others, or that the time limits are essentially arbitrary, it is also that the safeguards will steadily be eroded. Once the utilitarian argument has asserted itself, we will move inexorably towards a world where the worth of life is measured and questioned."[41]

3.2 The process relies on doctors certifying patients for assisted suicide, prescribing the lethal drugs, and being present when they are administered. Most physicians do not support a change in the law to legalise physician-assisted death, especially those with experience caring for terminally ill patients. Based on the 2019 survey published by the Royal College of Physicians, only 32% of doctors support the legalisation of physician-assisted death, with 43.4% of respondents opposing a change in the law.[42] (See also 2.8 above) A situation where so few doctors were willing to participate would lead to patients "shopping" for a compliant doctor who, inevitably, would be unfamiliar to them. In the decade following legalisation in Oregon (1997-2007), one quarter (62 out of 271) of all lethal prescriptions in Oregon were provided by just three doctors.[43] The 2020 Oregon Death with Dignity report notes that some assisted suicides were approved by doctors who had known the patients in

[38] BMA Survey on Physician-Assisted Dying, Research Report 2020, https://www.bma.org.uk/media/3367/bma-physician-assisted-dying-survey-report-oct-2020.pdf
[39] Royal College of Physicians, *Assisted dying survey 2019 results*, accessed from https://www.rcplondon.ac.uk/news/no-majority-view-assisted-dying-moves-rcp-position-neutral
[40] *ibid*
[41] Assisted Dying Bill [HL] Hansard 22 October 2021 https://hansard.parliament.uk/Lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL)#contribution-96AF0981-F4DC-4E44-A668-99AEC0037BAF
[42] https://www.rcplondon.ac.uk/news/no-majority-view-assisted-dying-moves-rcp-position-neutral
[43] Concentration of Oregon's Assisted Suicide Prescriptions & Deaths from a Small Number of Prescribing Physicians by Kenneth R. Stevens, Jr. MD Revised 3/18/2015

question for less than seven days. Only three out of the 245 who died were referred for psychological or psychiatric evaluation.

Many doctors oppose assisted suicide being part of mainstream healthcare, even if it is legalised.[44] It is not explained why it is doctors who should take on the role of ending life. Since the time of Hippocrates in the fifth century BC, medical ethics has sought to ensure that doctors dedicate their skills completely to life and healing, not to killing and suicide. The 1949 International Code of Medical Ethics states: "A doctor must always bear in mind the obligation of preserving human life."[45] Medicine should be the last profession to be actively involved in helping people to kill themselves.

3.3 Assisted suicide has no health benefits. It is not a medical procedure and should not be considered as such. Assisted suicide acts contrary to the goals of medicine, namely to cure and care but not to harm or kill patients. It must also be recognised that, from a psychological perspective, taking part in assisted suicide can be extremely onerous for physicians and others.[46]

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

Fully opposed: A process that is intended to end the life of a human being can never be considered safe.

4.1 The purpose of the Bill is to relax the prohibition on doctors ending the lives of their patients. As such no safeguards can be considered capable of preventing abuses since the actions sanctioned by the Bill, by their very nature, involve the abuse of medical ethics and human rights. The right to life is the most basic of all human rights. It is innate, universal and inalienable. Like liberty, it is not granted by governments, legislatures or courts of law. If the right to life of any category of person is violated, regardless of their consent, then the right to life of everyone is undermined.

4.2 Changing the law to allow some individuals to be killed, or helped to kill themselves, puts vulnerable people at risk of being killed against their will or pressured to kill themselves. Mistakes that result in the wrongful death of a patient can never be undone – death is final. Vulnerable people could easily become the target of undue influence, subtle pressure or coercion, or unintentionally be made to feel a burden. It is extremely difficult if not impossible to safeguard against these things.

The Reclaiming Our Futures Alliance (ROFA) is a national alliance of disabled people's groups and individuals. In 2015, at the time of the Marris Bill[47] which sought to legalise assisted suicide, ROFA issued the following statement:

> "We are opposed to the legalisation of assisted suicide. It will remove equality and choice from disabled people and further contribute to our oppression. If the Assisted Dying Bill is passed, some disabled people and terminally ill people's lives will be ended without their consent through mistakes, subtle pressure and abuse. No safeguards have ever been enacted or proposed that can prevent this outcome – an outcome that can never be undone."

4.4 The very fact of informing a patient that assisted suicide is an option could create pressure on a vulnerable patient. The description of assisted suicide as "dying with dignity" or "dignity in death"

[44] Keep Assisted Dying Out of Healthcare, "Assisted Dying and the Role of Mainstream Healthcare" https://**kadoh**.uk/ Accessed 4 November 2021
[45] International Code of Medical Ethics adopted by the Third General Assembly of the World Medical Association London, England, October 1949
[46] See EXIT - "Le Droit De Mourir", https://www.youtube.com/watch?v=7iNYTj_G03k
[47] The Assisted Dying Bill (2015) introduced by Rob Marris MP was defeated by 330 votes to 118 on 11 September 2015. https://publications.parliament.uk/pa/cm201516/cmhansrd/cm150911/debtext/150911-0001.htm#15091126000003 Accessed 4 November 2021

suggests to people with a terminal prognosis that their lives are a degradation and they would be better off dead. Whether or not this language is intended to convey that message, the value judgement implied by this choice of words is offensive and may be coercive. No one wishes to be told that their life is without dignity.

4.5 Experience shows that once assisted suicide and euthanasia become public policy, safeguards and monitoring standards are viewed as "obstacles" or "barriers" to access and are gradually abandoned. This has been seen in Canada, the Netherlands, Belgium, Washington, and Oregon.[48] Under Hawaii's Our Care Our Choice Act, a total of 59 people have died — 27 in 2019 and 32 in 2020. Official reports provide no information about the time to unconsciousness or the time taken to die, nothing on the reasons for requesting assisted suicide and nothing about who was present. A health department advisory group failed to hold even one board meeting in either 2019 or 2020 according to the annual reports. Despite this, the Hawaii health department has recommended further liberalisation.[49]

4.6 The assertion that Scottish law lacks the kind of safeguards and monitoring that exist in jurisdictions where assisted suicide has been legalised rests on a misrepresentation of the law. The current law offers significant deterrents for anyone seeking to exert an improper influence over a vulnerable person.

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

Fully opposed: Since legalised assisted suicide is shielded by doctor-patient confidentiality "in effect, any physician-assisted suicide regulation must, in the end, be physician self-regulated."[50]

5.1 Creating a body responsible for reporting and collecting data cannot address possible abuse. For example, in Oregon, doctors who supply lethal drugs to patients are required to declare this to the Oregon Health Authority (OHA) merely by ticking a series of boxes. There is no case review system to examine how requests for lethal drugs have been handled. As the OHA makes clear on its website, it does not investigate whether people who have been supplied with lethal drugs met the conditions laid down in the law. With such a closed system it is impossible to say that there has been no abuse of the law.[51]

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

6.1 Legislation relating to conscientious objections is the responsibility of the Westminster Parliament. The sponsors of the Bill cannot, therefore, provide any reassurances on the provision of conscience protection regarding:

i) which roles and personnel (eg, registered medical practitioners, nurses, pharmacists, residential care workers, etc) would have their Article 9 rights under the European Convention on Human Rights (Freedom of Conscience) respected and,
ii) whether entire institutions (such as hospitals, hospices or residential facilities) would be permitted to opt out or be legally compelled to comply with requests for assisted suicide.

[48] Wesley J Smith, 'Why the Hawaii Health Department Wants Looser Assisted-Suicide Rules' 28 August 2021, *National Review* https://www.nationalreview.com/corner/why-the-hawaii-health-department-wants-looser-assisted-suicide-rules/ Accessed 29 September 2021
[49] Michael Cook 'Has Hawaii forgotten that it legalised assisted suicide?' 5 September 2021, *Bioedge* https://www.bioedge.org/bioethics/has-hawaii-forgotten-that-it-legalised-assisted-suicide/13896 Accessed 29 September 2021
[50] Daniel Callahan and Margot White, 'The Legalisation of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village' (1996) 30 *Uni Richmond Law Rev* 1
[51] Living and Dying Well, "Truths & Half Truths About Assisted Dying," https://www.dyingwell.co.uk/wp-content/uploads/2021/05/Truths-and-Half-Truths-about-Assisted-Dying-A5-Final.pdf

6.2 The relatively small number of doctors prepared to take part personally in the prescription and administration of lethal drugs is likely to result in measures designed to curtail conscience rights. Protocols and guidance that require an objecting doctor to refer a patient to another physician for assisted suicide would not permit the exercise of conscientious objection in any meaningful sense. When the Joint Committee on Human Rights considered the Assisted Dying for the Terminally Ill Bill (2004) it raised the following concerns regarding conscience protection guaranteed by Article 9 of the Convention:

> 3.13 There is a tension, however, between this protection for freedom of conscience in clause 7(1) and the provision made in clauses 7(2) and (3), which impose a duty on physicians who invoke their right to conscientiously object, to "take appropriate steps to ensure that the patient is referred without delay to a physician who does not have such a conscientious objection".
>
> 3.14 We consider that imposing such a duty on a physician who invokes the right to conscientiously object is an interference with that physician's right to freedom of conscience under the first sentence of Article 9(1) because it requires the physician to participate in a process to which he or she has a conscientious objection. That right is absolute: interferences with it are not capable of justification under Article 9(2).[52]

Doctors who have a developed conscience and believe that all life is valuable should not be pressured to comply with a system in which their patients are killed, while those who are willing to play a part in killing their patients or helping them kill themselves are left unimpeded.

Question 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…

7.1 It is extremely concerning that the consultation indicates that the possible consideration of healthcare costs may be a factor in the legalisation of assisted suicide. The consultation states:

> "A cost analysis of assisted dying in Canada was undertaken in 2017 and concluded that "Medical assistance in dying could reduce annual health care spending across Canada by between $34.7 million and $138.8 million, exceeding the $1.5–$14.8 million in direct costs associated with its implementation. In sensitivity analyses, it was noted that even if the potential savings are overestimated and costs underestimated, the implementation of medical assistance in dying will likely remain at least cost neutral."[53]

According to Canada's Parliamentary Budget Officer, the Canadian health care system could save an estimated $149 million (£87 million) through assisted suicide in 2021 alone.[54] Not surprisingly, advocates of assisted suicide in Britain have argued that its legalisation could save money for the NHS. The late Baroness Warnock, who exercised great influence over medical ethics, spoke of a "duty to die" and said, "If you're demented, you're wasting people's lives - your family's lives - and you're wasting the resources of the National Health Services."[55]

---

[52] House of Lords, House of Commons Joint Committee on Human Rights *Scrutiny of Bills: Fifth Progress Report Twelfth Report of Session 2003-04*, 26

[53] Assisted Dying for Terminally Ill Adults (Scotland) Bill Consultation, Liam McArthur MSP, Footnote 123. The following reference is also provided: AJ Trachtenberg & B Manns "Cost analysis of medical assistance in dying in Canada," (2017) *CMAJ,* 189 (3): E101-E105. doi:10.1503/cmaj.160650.

[54] Office of the Parliamentary Budget Officer, "Cost Estimate for Bill C-7 'Medical Assistance In Dying'", 20 October 2020, https://www.pbo-dpb.gc.ca/web/default/files/Documents/Reports/RP-2021-025-M/RP-2021-025-M_en.pdf

[55] Baroness Warnock, "Dementia sufferers may have a 'duty to die,'" 18 September 2008, *Daily Telegraph* http://www.telegraph.co.uk/news/uknews/2983652/Baroness-Warnock-Dementia-sufferers-may-have-a-duty-to-die.html. Accessed 20 Mar 2020.

7.2 More recently, researchers have calculated the "wasted resources" spent on caring for terminal cancer patients.[56] The authors are quick to add: " …in no way is it intended to suggest that any such care should be denied to any patient".[57] Such a feeble denial, however, is unlikely to convince such patients that the constraints on NHS resources will not translate into subtle pressure for them to choose altruism and assisted suicide rather than ongoing care that will divert money from "more worthy" causes and patients whose prognosis is more positive.

7.3 The approach to assessing cost-effectiveness in the NHS — Quality Adjusted Life Years (QALYs) — is already used in treatment decisions for patients considered to have a poor quality of life. Under this formula, someone's life can be judged worse than being dead.[58] The supporters of the Bill can offer no guarantees that pressure on NHS budgets will not gradually lead to administrative policies that would view the promotion of assisted suicide as the preferred, possibly the only, treatment option for patients seen as a drain on NHS resources.

It is especially worrying that the issue of costs is being raised at a time when the public has been urged to "save the NHS" during the Covid crisis. No one should ever be encouraged to believe that hastening their death would reduce costs for the NHS. Baroness Grey-Thompson drew attention to this issue in the recent House of Lords debate on the Assisted Dying Bill 2021 when she stated:

> "Care packages are being cut. During the pandemic, "do not attempt resuscitation" orders were put on hundreds—that we know about—of disabled people with no underlying health conditions."[59]

If current pressures within the NHS can lead to the improper use of DNR orders, it is not unreasonable to assume that this would become an even more serious problem if laws on assisted suicide were to change.

Question 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?

Negative

8.1 Age. Older people would be more vulnerable to pressure to choose assisted suicide, both because of the prevalence of elder abuse and because many already feel that they are a burden. Legalisation will lead some vulnerable people to contemplate assisted suicide as a way to relieve family members, carers and broader society from the responsibility of providing care and support. In other words, if they perceive themselves as a burden they may be encouraged to seek a premature death in the belief that it would benefit others. The House of Lords Select Committee recognised this possibility in 1994 by indicating:

> "We are also concerned that vulnerable people - the elderly, lonely, sick or distressed - would feel pressure, whether real or imagined, to request early death. We accept that, for the most part, requests resulting from such pressure or from remediable depressive illness would be identified as such by doctors and managed appropriately. Nevertheless, we believe that the message which

[56] D Shaw & A Morton, "Counting the Cost of Denying Assisted Dying," (2020) *Clinical Ethics*, 15 (2) 65-70. https://journals.sagepub.com/doi/10.1177/1477750920907996 accessed 4 November 2021
[57] *ibid*
[58] Alan Williams 'The Value of QALYs' (1985) 94 *Health and Social Care J*, 3
[59] Assisted Dying Bill [HL] Second Reading, *Hansard*, 22 October 2021 https://hansard.parliament.uk/Lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL)#contribution-ADCCABCD-B4E6-414B-8EBE-175C9C21735E

> society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life."[60]

8.2 Disability. While disabled people are not necessarily ill, many chronic and terminal conditions can result in disability. Several of the points made about the elderly and seriously ill people also apply to those made vulnerable through disability. It is therefore understandable that disabled people fear the legalisation of assisted suicide and that this is opposed by UK organisations working closely with and on behalf of disabled people. These include:

- Scope
- Action on Elder Abuse
- Mencap
- Veterans Association UK[61]

8.3 Many of those who have travelled to other jurisdictions for assisted suicide have done so due to disability-related issues. Legalising assisted suicide means that some people who say they want to die will receive suicide intervention, while others will receive suicide assistance. The distinction in how these two groups will be treated will depend upon the state of their health or disability status. This will lead to a two-tiered system that results in death for those who are less valued socially.[62]

8.4 Race. Assisted suicide is particularly dangerous for marginalised groups. Proponents of assisted suicide have been characterised as ''white, well-off, worried, and well'', people who are less likely to understand the disproportionate impact of a change in the law upon the socially marginalised whose limited options for care and support seriously constrain their autonomous choices.[63]

8.5 Religion or belief. Many healthcare practitioners oppose assisted suicide for ethical or religious reasons because of the danger to the vulnerable or because it is not good medicine. The Bill will impact practitioners who reject assisted suicide because of their religion or belief.

Conclusion

As a matter of principle, physician-assisted suicide is a violation of medical ethics and fundamental human rights.

From a political perspective, however, there are two major obstacles that proponents of the Assisted Dying for Terminally Ill Adults (Scotland) Bill must overcome. Firstly, they must demonstrate that the current legal framework is not functioning as it should. And secondly, that the legislation which they seek to introduce is capable of overcoming the dangers inherent in assisted suicide and the wide-ranging negative consequences seen in other jurisdictions.

The supporters of the Bill have failed in both these critical areas. We, therefore, submit that the legislation should be withdrawn and that measures that genuinely address the current shortcomings in end-of-life care should be promoted in its place.

[60] House of Lords Select Committee Report on Medical Ethics, HL 21-I, 31 January 1994, 49, para 239
[61] Care Not Killing, "Charity chiefs denounce bill," 17 July 2014
http://www.carenotkilling.org.uk/letters/charity-chiefs-denounce-bill/
[62] Diane Coleman, "Not Dead Yet", in *The Case against Assisted Suicide: For the Right to End-of-Life Care*, (K Foley & H Hendin eds, John Hopkins University Press, 2002), 221.
[63] CJ Gill (2010) cited by Pike, 38