Date: 22 December 2021 – Liam McArthur MSP

Consultation: *Assisted Dying for Terminally Ill Adults (Scotland) Bill*

Consultation response on behalf of the Scottish Council on Human Bioethics

The **Scottish Council on Human Bioethics** (SCHB), which is an independent registered Scottish charity, is very grateful to Mr. Liam MacArthur MSP for this opportunity to respond to the consultation on the ***Assisted Dying for Terminally Ill Adults (Scotland) Bill.*** It welcomes his intention to promote public consultation, understanding and discussion on this topic.

Response to the Questions

1. Are you responding as:

☐ an individual – in which case go to Q2A
x on behalf of an organisation? – in which case go to Q2B

2A. 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".)

☐ Politician (MSP/MP/peer/MEP/Councillor)
☐ Professional with experience in a relevant subject
☐ Academic with expertise in a relevant subject
☐ Member of the public

Optional: You may wish to explain briefly what expertise or experience you have that is relevant to the subject-matter of the consultation:

2B. Please select the category which best describes your organisation:

☐ Public sector body (Scottish/UK Government or agency, local authority, NDPB)
☐ Commercial organisation (company, business)
☐ Representative organisation (trade union, professional association)
x Third sector (charitable, campaigning, social enterprise, voluntary, non- profit)
☐ Other (e.g. clubs, local groups, groups of individuals, etc.)

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).

The Scottish Council on Human Bioethics was formed in 1997 to provide a Scottish perspective on bioethical issues. It is an independent, non-partisan and non-sectarian organisation composed of doctors, lawyers, psychologists, ethicists and other professionals from disciplines associated with medical ethics. As such, the SCHB

functions as a multi-professional network with access to a range of specialist expertise and working groups. The principles to which the Scottish Council on Human Bioethics subscribes are set out in the United Nations Universal Declaration of Human Rights which was adopted and proclaimed by the UN General Assembly resolution 217A (III) on the 10th of December 1948.
The positions expressed in this response (below) are those of the 25 member SCHB Ethics Committee which examined this proposed Bill on behalf of the more than 100 SCHB members.

3. Please choose one of the following:

x I am content for this response to be published and attributed to me or my organisation
☐ ~~I would like this response to be published anonymously~~
☐ ~~I would like this response to be considered, but not published ("not for publication")~~

4. Please provide your name or the name of your organisation.

Scottish Council on Human Bioethics
Email:

5. Data protection declaration

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

☐ ~~Please tick this box if you are under 12 years of age.~~

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

Aim and approach

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

☐ ~~Fully supportive~~
☐ ~~Partially supportive~~
☐ ~~Neutral (neither support nor oppose)~~
☐ ~~Partially opposed~~
x Fully opposed
☐ ~~Unsure~~

Please explain the reasons for your response:

The Scottish Council on Human Bioethics (SCHB) recognises that some persons may wish for assistance to end their lives which they find unbearable. It understands that these are very difficult situations where a lot of compassion and sympathy are required.

However, the SCHB does not recognise the statement from Mr. Liam MacArthur indicating in the Foreword that: *"The current prohibition on such assistance is unjust and causes needless suffering for many dying people and their families across Scotland. If a person has reached the limits of palliative care and faces a bad death, none of the current options available to them in Scotland are likely to provide an acceptable alternative.*"[1]

This is because the legalisation of assisted suicide would be a dangerous precedent and would certainly put vulnerable people under pressure to consider ending their lives. In addition, the SCHB would like to question the suggestion that the legalisation of assisted self-killing of persons can ever be considered as an '*acceptable [and just] alternative*' in a civilised society.

[1] Assisted Dying for Terminally Ill Adults (Scotland) Bill Consultation, Liam McArthur MSP, Foreword.

Mr. MacArthur also indicates in the Foreword that "*the demand for change is growing and that people across Scotland want MSPs to take action to prevent suffering and extend compassionate end of life choices to include assisted dying*."[2] However, such a statement is prejudicial since those wanting to legalise assisted suicide do not have a monopoly on the concept of sympathy and kindness. Those opposed, are just as much motivated by genuine and sincere sympathy towards patients.

Furthermore, the proposed legislation does not promote compassion (which Mr. MacArthur mentions many times). The word 'compassion' in Latin means 'suffering with' but not ending the life of persons who are suffering. Therefore, it is not clear what Mr. MacArthur meant in using the term. Maybe he meant 'sympathy' which is derived from the Greek prefix 'syn' (meaning: with, together, con, plus) and the Greek noun 'pathos' (meaning: passion, suffering, emotion, feeling, obsession). Thus 'sympathy' is used both in Greek and English language to express and define feelings of sorrow, or pity for the hardships that another person encounters. Alternatively, Mr. MacArthur may have meant 'empathy' which is derived from the Greek preposition/prefix 'en' (meaning: in, on) and the noun 'pathos'. Thus, 'empathy', in the original Greek expresses an excess of personal emotion and passion, directed and projected towards a person. In English the word is used to describe the emotional identification with someone, and the power of projecting one's personality into, and so understanding the person (putting oneself in the place of another). In this respect, the balanced and non-directional meaning of 'sympathy' is generally considered to be the appropriate term to define the challenging and delicate physician-patient relationship.[3]

Mr MacArthur also presents a false dichotomy in the Foreword between accessing *"safe and compassionate assisted dying … rather than face the potential of a prolonged and painful death*". This is because with palliative care the choices are not mutually exclusive, while it is difficult to imagine killing as compassionate. He also speaks a plain untruth at the end of the Foreword by stating there is a "*blanket ban on the right to a compassionate death*"!

Furthermore, assisted suicide cannot be supported by the SCHB for the following reasons:

1.1. Inherent value and worth of human life is enduring and can never be lost

It is incorrect to suggest that any person can ever lose his or her inherent value and worth so that his or her life becomes meaningless. Though the inherent value of human life cannot be reduced to scientific concepts, it should always be recognised in every person to an equal extent. This is in accordance with the ***United Nations' Universal Declaration of Human Rights*** which affirms in its preamble "*the inherent dignity and … the equal and inalienable rights of all members of the human family"* as *"the foundation of freedom, justice and peace in the world".*

In this regard, the concept of what is 'inherent' reflects a Latin verb meaning 'to stick in' or 'adhere to'. When something is inherent, it means that it is permanent and is an essential or characteristic attribute. It is reflected in concepts such as inherence which expresses a quality which is embedded and vested in a person or group or attached to the ownership of a property. Thus, a person may be deprived of a right, but can never be deprived of his or her inherent human dignity.[4]

Moreover, the principle of equality associated to the inherent value of all human beings demands that all individuals believe that they have the same value and worth. This means that society has a choice between believing that all individuals have the same inherent value and worth which enables a just and civilised society to exist. Or it can believe and accept that some individuals can actually lose their inherent value or worth either completely or partially so that their lives should be ended. In this case a society based on equal rights ceases to (and cannot) exist.

At present, human beings live in a society where the inherent value of a human life is universal. This means each and every person is expected to acknowledge, respect and recognise the equal and inherent value of

[2] Assisted Dying for Terminally Ill Adults (Scotland) Bill Consultation, Liam McArthur MSP, Foreword.

[3] George T Vasileiadis, Peter N. McEwan, Tea and empathy, British Medical Journal 2005;330:229.

[4] Conor O'Mahony, There is no such thing as a right to dignity, *International Journal of Constitutional Law*, Volume 10, Issue 2, 30 March 2012, Pages 551–574.

others which cannot be created, modified or destroyed by an individual, a majority or a State. It is also independent of the suffering a person may experience. Indeed, in a civilised society, suffering cannot take precedence over the inherent value of life. Nobody can judge whether a life has lost it value and worth. Moreover, the worthiness and value of a life cannot depend on how much pleasure or suffering a person experiences during his or her life.

It is worth noting that a society that no longer believes in the inherent value of human life cannot offer any valid arguments against the taking of life of others, who may be considered unworthy of life. It becomes a society that has lost its trust in the inherent value and meaning of life and cannot comprehend why life should be endured in difficult or unpleasant circumstances. This is in complete opposition to a responsible, civilised, benevolent and compassionate society which continues to affirm and defend the lives of all its members and the notion that every human life is full of value, meaning and richness even though persons may be aged, dependent on others or may have lost the ability to express their autonomy. Therefore, in order to function consistently, society must reject assisted suicide if it does not want to undermine its most basic and fundamental values.[5]

1.2. Inherent value of life and the proper functioning of society takes precedence over absolute autonomy

Individual autonomy is very important in Western society, as it is linked to the concept of freedom. However, there is a danger that it may override/undermine the concept of the inherent value of human life. In addition, autonomy cannot be considered as an aspect of dignity since it cannot give any worth or value to any individual.[6]

By confusing autonomy as part of human dignity rather than a right flowing from it, some argue that a denial of autonomous decisions is a denial of human dignity. But what is really happening is simply a case of limitations being imposed on the right to personal autonomy. In addition, if the concept of individual autonomy is seen to be absolute, this contravenes the proper functioning of an interactive society. Accepting such an extreme form of autonomy would represent the atomisation and isolation of each human being. Civilised society, as such, would then cease to exist. Car drivers do not demand absolute autonomy in the manner in which they drive, so in the same way, individuals cannot demand absolute autonomy in the manner in which they live or die in a civilised society.

However, being dependent on others does not mean a loss of inherent dignity. We are all born dependent on others and, during our lives, are continually dependent in some way on others. It is only natural that as we age, we will become increasingly dependent on others. Being dependent on others in variable degrees and ways throughout our lives, is a basic characteristic of human existence.

Moreover, autonomy cannot take precedence over the inherent value of human life. It is only because society believes in the inherent value of human persons, that it respects their autonomy.[7] This inherent value of life is also specific to human beings as they cannot in law, or in a civilised society, just be considered as any other animal.

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

2.1. Palliative care can address the physical suffering of a terminally ill person

Studies from the most experienced hospice units have demonstrated that physical suffering and/or other symptoms can be effectively addressed in up to 95% of patients with appropriate medication, when treated by

[5] French National Consultative Ethics Committee for health and life sciences, The End of Life, Personal Autonomy, the Will to Die, 2013, p. 16-18. http://www.ccne-ethique.fr/sites/default/files/publications/avis_n_121_du_ccneeng.pdf

[6] Conor O'Mahony, There is no such thing as a right to dignity, International Journal of Constitutional Law, Volume 10, Issue 2, 30 March 2012, Pages 551–574.

[7] Likewise, the concept of a person being a burden to society is inimical to autonomy, as somebody who truly is autonomous by definition cannot be a burden.

healthcare professionals with the relevant expertise.[8,9] Similarly, patients with an illness such as motor neurone disease (a serious progressive neurological disorder) are often afraid of choking to death, but this virtually never happens with appropriate palliative care.[10] Thus, palliative care can help patients (and sometimes their families), by calming their symptoms. Usually, the patient requires a gradually increase of the amount of medication to keep symptoms under control. However, on occasions the doses may need a more rapid increase for patient safety and comfort, as well as for the distress of onlookers.

Experts also agree that most physical suffering and the possible associated psychological distress or depression can generally be relieved by a holistic approach.[11] Thus, physical suffering or depression should not be a motive for assisted suicide if appropriate palliative care and support are available.[12] As Dr. Linda Ganzini, Professor of psychiatry and medicine in the US state of Oregon (which has legalised Assisted Suicide) and a senior scholar of the centre of ethics and health care at Oregon Health and Science University, indicated when giving oral evidence to the Scottish Parliament in 2010:

> *"It would be highly unusual for a patient to choose assisted suicide purely because of pain [physical suffering] that they were experiencing that could not be treated. Interestingly, the majority of patients who pursue assisted suicide in Oregon have very low symptom burden when they pursue it; they are anticipating symptom burden in the future ... that will undermine their autonomy. It is really not about pain."*[13]

Nonetheless, there will always be occasions where a patient's symptoms cannot be completely controlled. This is more common in patients who are restless due to fear or an unresolved family or personal issue or cannot cope with a particular symptom, such as severe breathlessness. Some may also have significant psychological and/or existential distress which they find difficult to address. Almost all patients with symptoms which cannot be completely controlled have elements of this distress which is not recognised as physical. But there is always something more palliative care can do to address this suffering. For example, individuals, who are already drowsy and dying of their illness, may request some form of sedation to relieve the suffering, in which case it may be possible to manage their distress and agitation while minimising side effects. Indeed, the administration of appropriate amounts of sedative drugs may be considered as an acceptable treatment when persons are in the dying stages to manage distress and restlessness. These indications can occasionally occur when patients are no longer capable of working through their issues or are barely conscious as a result of their disease (rather than the drugs). Moreover, if the causes of the agitation and symptoms such as sickness, excess secretions and confusion are carefully assessed, management can be aimed at each particular problem without the need for excessive sedation.

Thus, drugs may sometimes be administered and monitored to induce a state of decreased or absent awareness

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[8] Organisations such as the Hospice Movement reveal that suffering can be adequately alleviated in all but the rarest cases.
See also: http://www.bbc.co.uk/ethics/euthanasia/against/against_1.shtml Pain: Some doctors estimate that about 5% of patients don't have their pain properly relieved during the terminal phase of their illness, despite good palliative and hospice care.

[9] When correctly used to relieve pain in a patient who is terminally ill, morphine should never cause death. By contrast it may lengthen life and improve its quality. This is because the therapeutic dose of morphine, which relieves pain, is virtually always well below the toxic dose which ends life and because the relief from pain which it brings removes stress factors in the patient's condition. In addition, toxic doses risk causing increased agitation in some patients.

[10] Unfortunately not many motor neurone disease patients die in a hospice as they need longer term care than that provided by such centres. It is important, for society to increase funding to manage these patients in hospices. The hospice movement has shown that with good care these patients can have quality of life and a peaceful end.
Neudert C, Oliver D, Wasner M, Borasio GD., The course of the terminal phase in patients with amyotrophic lateral sclerosis. J Neurol. 2001 Jul;248(7):612-6.

[11] Sometimes, depression is not appropriately treated in end of life patients due to a range of factors such as failure to diagnoses depression and failure to identify the underlying causes of depression.
See: Linda Ganzini, Elizabeth R Goy, Steven K Dobscha, Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey, BMJ 2008; 337, a1682

[12] French National Consultative Ethics Committee for health and life sciences, The End of Life, Personal Autonomy, the Will to Die, 2013, p. 14.

[13] Linda Ganzini, Scottish Parliament, End of Life Assistance (Scotland) Bill Committee, Official Report**,** *Tuesday 7 September 2010, Col. 67,* http://www.scottish.parliament.uk/s3/committees/endLifeAsstBill/or-10/ela10-0402.htm

(unconsciousness) in order to increase comfort in the dying process while not necessarily shortening life.[14] This is dose dependent and high levels of opiates can actually increase problems if administered at toxic levels, such as limiting fluid intake and suppressing respiration. Rarely, agitation is such that very high doses are required but clinicians tend to be wary of using high doses in case they bring about premature death.[15]

In addition, the SCHB does not understand what Mr. MacArthur means by the statement that a person can "*reach the limits of palliative care*". Moreover, his statement that "*too many Scots still face a bad death, some enduring physical and emotional suffering even when high-quality specialist palliative care is present*"[16] lacks evidence. Palliative care has reached a high level of expertise, and it is very rare that continuous sedation is required to keep a lucid patient asleep in order to address significant physical and/or mental distress. Deliberately sedating patients to deal with their suffering is a very rare occurrence in the UK.

However, it is important that patients with difficult symptoms are aware that complete relief is sometimes beyond the realm of medicine. In this regard, it is worth noting that palliative care not only includes medical assistance but endeavours to provide non-clinical support and the right environment for patients to express and work through their distress.[17] Thus, few patients request assisted suicide when their physical, emotional and spiritual needs have been adequately addressed.

Finally, a requirement should exist that enables relatives to grieve when their loved-one is dying. They need to also know that they are supported and 'did what they could' to help him or her in the last weeks and days of his or her life.

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

☐ ~~Fully supportive~~
☐ ~~Partially supportive~~
☐ ~~Neutral (neither support nor oppose)~~
☐ ~~Partially opposed~~
x Fully opposed
☐ ~~Unsure~~

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

3.1. Assisted suicide should not be considered as a medical procedure

Assisted suicide undermines the traditional goal of medicine, namely to cure and care but not to harm or kill patients. It is also important to recognise that it is not easy, from a psychological perspective, for a physician (or any other person) to take part in assisted suicide.[18] They would be expected to actively assist a person kill themselves in front of their eyes. And this may not always go smoothly with the dying process sometimes being violent, long-lasting and unpleasant. They would not usually be expected to leave the dying person to die if they

[14] Nathan I Cherny, Sedation for the care of patients with advanced cancer, *Nature Reviews Clinical Oncology* 3, 492-500 (2006).
Susan Anderson Fohr. 'The Double Effect of Pain Medication: Separating Myth from Reality', Journal of Palliative Medicine. April 2005, 1(4): 315-328.
Nigel Sykes, Andrew Thorns, 'Sedative Use in the Last Week of Life and the Implications for End-of-Life Decision Making', Arch Intern Med. 2003;163(3):341-344.

[15] In a Europe-wide study, the highly variable results bring into question whether existing guidelines for pain relief were applied appropriately. Bilsen J. et al. Drugs used to alleviate symptoms with life shortening as a possible side effect: end-of-life care in six European countries, *J Pain Symptom Manage*. 2006 Feb;31(2):111-21.

[16] Assisted Dying for Terminally Ill Adults (Scotland) Bill Consultation, Liam McArthur MSP, Foreword.

[17] For example, with the consent of the patient, the number of visitors may be reduced so that he or she can work things through.

[18] See: EXIT - LE DROIT DE MOURIR, https://www.youtube.com/watch?v=7iNYTj_G03k

find the process to be traumatic thus undermining their own autonomy. The British Medical Association indicated in 2020 that 54% of members who responded to a survey said that they would not be willing to actively participate in the process of administering life-ending drugs, should this be legalised. A quarter (26%) said they would, and one in five (20%) were undecided on the matter.[19]

Physicians may be challenged to even refer patients to other physicians for assisted suicide. The restriction on the autonomy/freedom of physicians in referring the patients is worrying. Patients, or their families could seek other opinions themselves, without compromising the conscience of their physician. There is presumably plenty of available information about alternative providers. Thus, the physician may not wish to access or refer, but would be able to give their patients their own medical records should they ask for them.

Research, moreover, indicates that the most sustained demands for assisted suicide are actually considered by persons suffering from existential problems or because they have an extreme concept of control and independence.[20] This means that the argument in favour of assisted suicide is more about control than medicine. For example, the already mentioned Prof. Linda Ganzini in Oregon indicated in 2010, that the main reason for many persons wanting assisted suicide was control. She explained: **"***The problem is that in Oregon we really admire these very independent, individualistic people as part of our history. Some people may come across them and say, "They are control freaks," but in Oregon we admire them*".[21]

3.2. Assisted suicide would undermine the relationships of health care professionals with their patients

While all admit the inevitability of death, intentionally and actively pursuing the death of a patient, fundamentally changes the role of the physician, changes the doctor-patient relationship and changes the role of medicine in society.

Some physicians may then become hardened to death and to causing death, particularly when patients are old, terminally ill, or disabled. Legalising assisted suicide would then give persons, such as physicians, power that could be too easily abused, and a responsibility that they should not be permitted to have. It is not up to physicians to decide whether or not a life is worthwhile.[22] If assisted suicide was to be accepted, a number of vulnerable people and their families may begin to mistrust the real intentions of their doctors.

At present, when a patient discusses his or her wish for assisted suicide with his or her physician, this is framed primarily around trying to establish the reasons behind that wish. But if assisted suicide was to be legalised, it would very much change the discussion to one in which the patient is seeking the view and eventual support from the physician that his or her life no longer has any meaning or worth.

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

☐ ~~Fully supportive~~
☐ ~~Partially supportive~~
☐ ~~Neutral (neither support nor oppose)~~
☐ ~~Partially opposed~~
x Fully opposed
☐ ~~Unsure~~

[19] https://www.bma.org.uk/media/3367/bma-physician-assisted-dying-survey-report-oct-2020.pdf

[20] Linda Ganzini, et. al., Physicians' Experiences with the Oregon Death with Dignity Act, The New England Journal of Medicine, Vol 342, February 2000.

[21] Linda Ganzini, Scottish Parliament, End of Life Assistance (Scotland) Bill Committee, Official Report**,** *Tuesday 7 September 2010, Col. 67,* http://www.scottish.parliament.uk/s3/committees/endLifeAsstBill/or-10/ela10-0402.htm

[22] In very rare cases, physicians such as Harold Shipman, may actually feel empowered in being able to provoke death. Harold Shipman: The killer doctor, BBC News, 13 January 2004, http://news.bbc.co.uk/1/hi/uk/3391897.stm

Please explain the reasons for your response.

4.1. Assisted suicide laws are dangerous

Mr. MacArthur indicates in his Foreword that*:*

> *"The proposal presented in this Consultation is one that co-exists with support for more and better palliative care and applies only to terminally ill, mentally competent adults. It has strong safeguards that put transparency, protection and compassion at its core and is modelled on legislation that has passed rigorous testing in other countries around theworld."* [23]

He goes on to indicate that: "*A consideration of the lived experiences of our citizens alongside the available research, both nationally and internationally, shows that assisted dying laws can be implemented safely and successfully, and concerns can be addressed by implementing robust safeguards*."[24]

However, the legalisation of assisted suicide may impose upon medical professionals obligations which may be unworkable with the possibility of penalties (or prosecution) applying if these are not respected. Present legislation, however, is appropriate to address every different case in the Scottish courts while allowing compassion.

In addition, the SCHB is of the view that Mr. MacArthur is misinformed and mistaken in his belief that safeguards will ensure that no abuse takes place. In fact, the reverse would be true. It is also worth noting that the last available official report on assisted suicide in Oregon indicated that:[25]

- The reported complication rate was nearly 7%, including one case of seizures.

- Despite continued experiments with lethal drug combinations in 2020, three people took six hours or more to die. One of them took 8 hours.

Because of this, in countries where both assisted suicide and euthanasia are possible, it is euthanasia that is preferred since less complications are experienced.

Moreover, where assisted suicide has been legalised around the world, this shows (see following) that significant dangers now arise relating to the protection of the most vulnerable while a general devaluation of life in society is experienced.

4.2. The state cannot control what is seen as normal with assisted suicide

Interestingly, the normality of a procedure may be affected by its legalisation. This is because, for a number of individuals, what is perceived as legally possible may influence what they believe they can do and what is normal. This idea was also reflected by the Health and Sport Committee of the Scottish Parliament which indicated in 2015 that "*when law permits a practice, this is perceived as endorsement, and as society absorbs that endorsement, the general perception of the practice changes*."[26] In other words, the legalisation of a certain procedure may influence the manner in which this procedure is regarded which can then be the basis for further changes.

It has also long been acknowledged that any piece of legislation cannot control all the different manners in which it may eventually be used. Because of the sheer number of different applications which arise in a large country, most legislations will eventually be pushed to their limits as was the case, in the past years, with the euthanasia

[23] Assisted Dying for Terminally Ill Adults (Scotland) Bill Consultation, Liam McArthur MSP, Foreword.

[24] Assisted Dying for Terminally Ill Adults (Scotland) Bill Consultation, Liam McArthur MSP, Foreword.

[25] Oregon Death with Dignity Act 2020 Data Summary, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf

[26] Health and Sport Committee of the Scottish Parliament, Stage 1 Report on Assisted Suicide (Scotland) Bill, 30th April 2015, SP Paper 712, 6th Report, Session 4 (2015), p.52, paragraph 275.

(which includes assisted suicide) provisions in Belgium. As Paul Vanden Berghe (from the Federation of Palliative Care in Flanders) et al., indicates "*there is an indication that euthanasia, once the barrier of legalisation is passed, tends to develop a dynamic of its own and extend beyond the agreed restrictions, in spite of earlier explicit reassurances that this would not happen – in Belgium, such reassurances were given when the 2002 law was being debated*."[27]

Similarly, the Belgian legal scholar, Etienne Montero, explains that when 'precedents' and 'exceptions' exist they usually tend to expand the law[28] while concluding: "*The Belgian experience teaches that once euthanasia is permitted, it is very difficult to maintain a strict interpretation of the fixed legal conditions. By interpreting in different ways indications for euthanasia, they continue to diversify despite of the original declarations and intentions of the legislator.*"[29]

4.3. Extension of the qualifying conditions for assisted suicide

In certain countries, such as in Belgium and The Netherlands, there is now evidence of an incremental extension in the scope of assisted suicide. In other words, there is a steady increase in numbers with a gradual widening of the categories of persons with respect, for example, to age and the seriousness of the condition, as well as who can be considered for assisted suicide, implying that the value and worth of certain lives, in these countries, is diminishing.

Furthermore, legislation often comes under pressure because once a procedure begins to be considered as normal, a tendency then exists for procedures, only slightly different from the original one, to also be included in what should be considered as normal. This usually takes place through a reasoning process whereby it is demonstrated that the new procedures do not differ, in any significant or meaningful manner, to the one that has previously been accepted and legalised by society.

Since it is likely that the very basis for accepting euthanasia and assisted suicide in Belgium came as a response to what was considered to be (1) unbearable suffering and (2) a support for autonomy, a number of consequences may then arise. These include the suggestion that when any individual's suffering becomes unacceptable or his or her autonomy is threatened, assisted suicide could be considered as acceptable. If this is refused, it would be for society and the government to give appropriate reasons for allowing assisted suicide in one set of circumstances but not in another.

To some extent, there is a certain rationale to this continuous extension of qualifying conditions for assisted suicide.[30] If one set of applications are accepted as new, compelling reasons for change become more reasonable through the process of acclimatisation, whereby individuals adjust to a gradual change in their social environment. Through such a process, previous applications may be seen to become more acceptable and normal. A form of desensitisation may also be taking place whereby a procedure may no longer be seen as contentious since it is now in a new social setting.[31] As indicated by American legal academic, Eugene Volokh, *"[E]very decision changes the political, economic and psychological conditions under which future decisions are made*".[32]

The legal scholar in the USA, John Keown, illustrates this reasoning by presenting two imaginary identical twin patients who are both affected by the same terminal illness and suffering to the same extent though one of them is mentally competent while the other is not. In this regard, if the one who is competent is given access to

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[27] Paul Vanden Berghe, Arsène Mullie, Marc Desmet and Gert Huysmans, Assisted dying – the current situation in Flanders: euthanasia embedded in palliative care, European Journal of Palliative Care, 2013; 20(6), p. 271.

[28] Etienne Montero, Rendez-vous avec la mort: Dix ans d'euthanasie légale en Belgique, Limal: Anthemis, 2013, p. 75.

[29] Etienne Montero, Rendez-vous avec la mort: Dix ans d'euthanasie légale en Belgique, Limal: Anthemis, 2013, p. 128.

[30] Volokh E. The mechanisms of the slippery slope. Harv L Rev. 2003;116:1026–137. doi: 10.2307/1342743.

[31] Den Hartogh G. The slippery slope argument. In: Kuhse H, Singer P, editors. Companion to Bioethics. Malden, MA: Wiley–Blackwell; 2009. pp. 321–32.

[32] Cited in: M.J. Shariff, Assisted death and the slippery slope—finding clarity amid advocacy, convergence, and complexity, Curr Oncol. Jun 2012; 19(3): 143–154. doi: 10.3747/co.19.1095

assisted suicide because he is capable of making a responsible decision and is experiencing unbearable suffering, it would be difficult to make a strong case opposing euthanasia for the second twin. This is because even though he does not have the mental capacity to make the decision, he would be seen as suffering in a similar manner to the first twin.[33]

Keown concludes that while legislation may be drafted seeking to limit assisted suicide upon request by individuals experiencing significant suffering, the justification for assisted suicide, when taken to its logical conclusion, would also become reasonable for individuals who do not have the capacity to request assisted suicide and to those experiencing less severe forms of suffering.[34] In other words, it is through acclimatisation to the procedures and on the basis of reasoned arguments relating to new applications that an extension of qualifying conditions for assisted suicide may take place.

Relating to the possible extension of the qualifying conditions of assisted suicide, it is also useful to look at what has verifiably happened in The Netherlands. In this respect, concern has been expressed by Canadian palliative care expert, José Pereira, while commenting on the verifiable developments that have taken place over the years in this country. He indicates:

> *"In 30 years, the Netherlands has moved from euthanasia of people who are terminally ill, to euthanasia of those who are chronically ill; from euthanasia for physical illness, to euthanasia for mental illness; from euthanasia for mental illness, to euthanasia for psychological distress or mental suffering—and now to euthanasia simply if a person is over the age of 70 and "tired of living." Dutch euthanasia protocols have also moved from conscious patients providing explicit consent, to unconscious patients unable to provide consent."*[35]

Pereira then goes on to explain that it is now considered a form of discrimination to deny euthanasia or assisted suicide in The Netherlands to persons with any form of disorder on the grounds that it is unfair that persons who are suffering, but not dying, are forced to suffer longer than those who are terminally ill. Even non-voluntary euthanasia in The Netherlands is now being presented as a social duty of the state on the basis of the ethical principle of beneficence.[36]

Because of a similar manner of reasoning, about 20 proposals to change the law have already been introduced in the Belgian parliament with the aim of extending the qualifying conditions under which euthanasia (which includes assisted suicide) can be performed.[37] Each time, there is a certain logical reasoning, based on notions such as equality and justice, behind the proposals highlighting, for example, forms of suffering which were not included in the original euthanasia legislation.

In this way, those supporting an extension of the 2002 legislation on euthanasia in Belgium have already denounced the arbitrariness of some of its criteria including the requirement:[38]

- That a disorder should exist as a result of a disease or accident excluding those who are simply aged or tired of living;

- For intolerable suffering to exist while excluding those who only expect this suffering to be present in the future.

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[33] John Keown, 2002. *Euthanasia, Ethics and Public Policy*. Cambridge: Cambridge University Press, p. 78.

[34] John Keown, 2002. *Euthanasia, Ethics and Public Policy*. Cambridge: Cambridge University Press, p. 80.

[35] J. Pereira, Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls, Current Oncology, 2011, Volume 18, Number 2, p. e.43

[36] J. Pereira, Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls, Current Oncology, 2011, Volume 18, Number 2, p. e.43

[37] Schamps, G. and Overstaeten, M., "La loi belge relative à l'euthanasie et ses développements", in Liber amicorum Henri-D. Bosly, La Chartre, 2009, 0. 337-355.

[38] Paul Vanden Berghe, Arsène Mullie, Marc Desmet and Gert Huysmans, Assisted dying – the current situation in Flanders: euthanasia embedded in palliative care, European Journal of Palliative Care, 2013; 20(6), p. 270-271.

Further changes to the law have also been suggested in 2011 by physician, Wim Distelmans, the chairman, at the time, of the Belgian official Federal Committee on Euthanasia, including:[39]

- The five year validity limit for advance directives should be removed;
- Physicians who oppose euthanasia should be compelled to refer patients to colleagues who are willing to help with the procedure;
- The euthanasia of persons with dementia should be made possible if they have an advance directive stating that this would be their preference;
- No lower age limit for euthanasia should exist (which has since been decriminalised in 2014).

This all means that it is very likely that an extension of the qualifying conditions will continue to be considered in Belgium especially if the legal situation is continually challenged. For example, police in The Netherlands indicated in 2021 that they are investigating the deaths of dozens of people who purchased a suicide powder from members of a fundamentalist euthanasia group called Cooperatie Laatste Wil (CLW, Last Wish Cooperative). So far, three members of the group which promotes "assisted suicide and self-euthanasia without the intervention of doctors", have been arrested. One of these was Wim van Dijk, 78, who openly admitted to the media that he had sold the suicide powder illegally to more than 100 people. He expressed his defiance by indicating: "*I am aware of the consequences of my story. I don't care. I want the social unrest to become so great that the judiciary cannot ignore it. I don't really care if they arrest me or put me in jail. I want something to happen*."[40]

4.4. Euthanasia becoming a human right

In Belgium, the nearest relatives representing the patient are increasingly describing the dying process as "*undignified, useless and meaningless"*[41] even if the death takes place peacefully, without suffering and with appropriate expert support. Moreover, there is a growing trend for nearest relatives to often insist, sometimes even forcefully, that healthcare professionals should provide fast and active interventions for the ending of life of an elderly parent.[42] As such, there seems to be a growing sense of entitlement or even a perceived right to euthanasia and assisted suicide amongst certain members of society and the media.[43]

In addition, because of the extension of the qualifying conditions to children and those persons who are increasingly losing their cognitive faculties, an imperceptible change may be taking place in Belgium from a 'right to end one's life' to a 'right to end the life of another'. This is because it may be impossible for persons with very limited cognitive abilities to ever be able to appropriately kill themselves.[44] John Keown emphasises: "*Once the law abandons its historic, bright-line prohibition on intentionally ending the lives of patients, or on intentionally helping them to end their own lives, it invites arbitrary and discriminatory judgments about which patients would be 'better off dead'*."[45]

Moreover, Montero explains that euthanasia, in Belgium, has imperceptibly developed into the perceived most

[39] Wim Distelmans, Open brief aan Di Rupo: 'Pas euthanasiewet eindelijk aan', 2011, http://www.leif.be/images/stories/Artsenkrant_-_Open_brief_aan_Di_Rupo_-_Pas_euthanasiewet_eindelijk_aan_15-11-11.pdf (Accessed 10.02.15)

[40] https://bioedge.org/end-of-life-issues/euthanasia/euthanasia-fundamentalists-still-at-work-in-the-netherlands-selling-mittel-x/

[41] Paul Vanden Berghe, Arsène Mullie, Marc Desmet and Gert Huysmans, Assisted dying – the current situation in Flanders: euthanasia embedded in palliative care, European Journal of Palliative Care, 2013; 20(6), p. 271.

[42] Paul Vanden Berghe, Arsène Mullie, Marc Desmet and Gert Huysmans, Assisted dying – the current situation in Flanders: euthanasia embedded in palliative care, European Journal of Palliative Care, 2013; 20(6), p. 271.

[43] Etienne Montero, Rendez-vous avec la mort: Dix ans d'euthanasie légale en Belgique, Limal: Anthemis, 2013, p. 91-96.

[44] Etienne Montero, Rendez-vous avec la mort: Dix ans d'euthanasie légale en Belgique, Limal: Anthemis, 2013, p. 86-91.

[45] John Keown, Physician-assisted Suicide: Some Reasons for Rejecting Lord Falconer's Bill, Care Not Killing Alliance, 2014.

humane and dignified answer to a situation of suffering. As the threshold of acceptable sickness and suffering diminished, euthanasia and assisted suicide have become unexceptional[46] and are no longer seen as ethical transgressions. Because of this, they have started to be considered as belonging to the full set of practices that should be available in palliative care.[47,48]

In Belgium, already 10% of children who die before their first birthday are the result of a euthanasia procedure, making the procedure become just another form of infanticide.[49]

4.5. The request to die may not reflect the patient's real wishes

Though sadness may be present in a patient faced with the news of his or her approaching death, this may be seen as a normal response in such a situation. Generally, however, experience shows that once people receive appropriate palliative care and are comfortable, with their fears concerning suffering being addressed, they often change their minds about wanting to end their lives.[50]

MacArthur states in section 2.2 that "*People living with terminal illness have an increased likelihood of attempting to end their own life"*, but the reasons for this needs to be explored. It may be that they have not resolved some issues, they are depressed, lonely or abandoned. Often at the end of life, patients are ready to die and if this takes time, may be express a wish to die, as they are tired. However, this is not usually a cry to be killed but a form of preparation for the inevitable, an adjustment of their goals and an acceptance of their condition. This acceptance can be a good thing, as it can help them prepare and sort out their affairs and relationships with others.

There is good evidence that a desire for death in terminally ill patients can vary with time and is closely associated with clinical depression which can be alleviated by personal support and treated in most cases.[51] States of delirium and/or confusion are common in palliative care patients and are sometimes so subtle that they are difficult even for clinicians to recognise. It is impossible to be absolutely sure that a request for a life to be ended does not arise from a disordered state of mind. Moreover, detecting depression is very difficult even for a specialist practitioner, let alone a GP. This is especially difficult for a patient who has a chronic physical illness.

In other words, whilst many people are competent to make decisions about their wish for assisted suicide, many are not. This opens up the possibility that a decision to end a person's life could be made by a second person such as a nominated proxy. The complexities arising from such conditions could lead to serious abuse.

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

☐ ~~Fully supportive~~
☐ ~~Partially supportive~~
☐ ~~Neutral (neither support nor oppose)~~
☐ ~~Partially opposed~~
x Fully opposed
☐ ~~Unsure~~

[46] Etienne Montero, Rendez-vous avec la mort: Dix ans d'euthanasie légale en Belgique, Limal: Anthemis, 2013, p. 62.

[47] Paul Vanden Berghe, Arsène Mullie, Marc Desmet and Gert Huysmans, Assisted dying – the current situation in Flanders: euthanasia embedded in palliative care, European Journal of Palliative Care, 2013; 20(6), p. 267.

[48] Etienne Montero, Rendez-vous avec la mort: Dix ans d'euthanasie légale en Belgique, Limal: Anthemis, 2013, p. 94.

[49] Dombrecht L, Beernaert K, Chambaere K, et al, End-of-life decisions in neonates and infants: a population-level mortality follow-back study Archives of Disease in Childhood - Fetal and Neonatal Edition Published Online First: 15 June 2021.

[50] Van Der Maas PJ, Van Delden JJM, Pijnenborg L, Looman CW. Euthanasia and other medical decisions concerning the end of life, Lancet, Vol. 338, 1991.

[51] Linda Ganzini, et. al., Physicians' Experiences with the Oregon Death with Dignity Act, The New England Journal of Medicine, Vol 342, February 2000.

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. Creating a body responsible for reporting and collecting data cannot address possible abuse

In a 2018 letter to the *European Journal of Epidemiology*, researchers from the End-of-Life Care Research Group at the Free University of Brussels admit that "*death certificates substantially underestimate the frequency of euthanasia as a cause of death in Belgium and are therefore an unreliable tool for monitoring its practice*." According to a large sample of death certificates, 0.7% of all deaths were described as euthanasia, but the anonymous survey of doctors yielded a figure of 4.6% of all deaths.[52]

A 2021 article, which was published in the *Journal of Medicine and Philosophy*, indicated that in Belgium a widening of the use of euthanasia is occurring and that this is giving rise to a number of significant ethical difficulties.[53] The authors note: *"This is in part related to the fact that several legal requirements intended to operate as safeguards and procedural guarantees in reality often fail to operate as such*."

One of these areas is the reporting of euthanasia cases to the Federal Control and Evaluation Commission for Euthanasia. Indeed, the legislation which was promoted as giving greater clarity, transparency and control to end of life practices, has not fulfilled expectations. The system of official reports and the work of the Federal Commission in Belgium offer neither transparency nor control. Instead, it seems to provide only the illusion of control.

And this situation has only worsened over the years. Indeed, the aforementioned 2021 article indicates that the Commission does not appropriately check the fulfilment of various legal criteria but seems to simply act, instead, as a shield to prevent possible problematic cases being referred to the Public Prosecutor. In addition, it sometimes reinterprets the Euthanasia legislation as it sees fit which is completely beyond its remit. Significant conflicts of interest also exist in the composition of the 16-member evaluation committee, including with the chairman Dr. Wim Distelmans, who supports and regularly performs euthanasia. Ever since euthanasia was legalised in 2002, the Belgian Commission has only referred one case to the Public Prosecutor and the doctor was eventually acquitted. There is thus a very serious lack of accountability in Belgium relating to euthanasia and assisted suicide procedures which can only end in disarray and a lack of protection of the most vulnerable. Thus, if a comparable body was established in Scotland, it is expected that a similar outcome would arise.

This all means that the only appropriate body capable of examining each different case of assisted suicide in a careful, compassionate and considered manner are the official Scottish courts. Moreover, in some cases of assisted suicide, the perpetrator will still deserve to be prosecuted. For example, from 1 April 2009 up to 31 July 2021 in England and Wales, 171 cases were referred to the Crown Prosecution Service (CPS) by the police that have been recorded as assisted suicide. Of these 171 cases, 111 were not proceeded with by the CPS and 32 cases were withdrawn by the police. However, three cases of encouraging or assisting suicide have been successfully prosecuted. One case of assisted suicide was charged and acquitted after trial in 2015 and eight cases were referred onwards for prosecution for homicide or other serious crime.

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. It is not conscientious objections but conscientious acceptance that should be examined.

The legalisation of assisted suicide may undermine the autonomy and impose a level of coercion on medical and other health care professionals or on dependent and vulnerable individuals. They may then feel obliged to carry out an act of assisted suicide against their wishes or personal beliefs.

[52] Cohen, J., Dierickx, S., Penders, Y.W.H. et al. How accurately is euthanasia reported on death certificates in a country with legal euthanasia: a population-based study. Eur J Epidemiol 33, 689–693 (2018).

[53] Kasper Raus, Bert Vanderhaegen, Sigrid Sterckx, Euthanasia in Belgium: Shortcomings of the Law and Its Application and of the Monitoring of Practice, *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*, Volume 46, Issue 1, February 2021, Pages 80–107.

The SCHB would also like to question why persons who have a robust, responsible and highly developed conscience, and who believe that all lives are of equal value, should be regulated while those who do not are not challenged. Indeed, the conscientious acceptance of some parliamentarians in seeking to legalise the ending of the lives of individuals should be examined. Thus, an urgent study of these parliamentarians, elected on the basis of the democratic value of equality and the rule of law, is necessary to find out why they no longer accept or believe in the equal value of all human life and that some lives can be considered as unworthy of life.

6.2. Legislation relating to conscientious objections is the responsibility of the UK Parliament in London

The SCHB notes that legislation relating to conscientious objections is not the responsibility of the Scottish parliament but of the UK Parliament in Westminster.

Financial implications

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

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

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

The cost (or savings) of assisted suicide to a healthcare system are only just beginning to be discussed in the literature. In this regard, the Scottish academic and ethicist, David Shaw, proposed to defend a number of economic arguments in 2020 for permitting assisted dying, which (he suggests) "*are supplementary arguments that should not be neglected when considering the ethics of assisted dying*". These include the argument that "*the resources consumed by patients who are denied assisted dying could instead be used to provide additional (positive) quality-adjusted life years for patients elsewhere in the healthcare system who wish to continue living and to improve their quality of life*." He also mentions that organ harvesting from individuals who have used assisted dying could be used as "*an additional potential source of quality-adjusted life years in this context*."[54]

Moreover, in the Mr MacArthur's consultation document, it is indicated that:

> "*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*."[55]

In this regard, it is extremely concerning that the consultation indicates that the consideration of healthcare costs may be a factor in the legalisation of assisted suicide.

The economic issues are, of course, significant in a private health system, but even in a welfare state such as in the UK, there are expenditures if someone lives longer, resulting in less inheritance for the family. It would indeed

[54] Shaw D, Morton A. Counting the cost of denying assisted dying. *Clinical Ethics*. 2020;15(2):65-70.

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

be a poor reflection on a society if an economic value were placed on people, and worse still if that should be a motive for bringing about their death. In addition, the possible motivation by family members to support assisted suicide may be questionable and may even include financial gain if the support costs of the relative are very high.

Finally, even though Mr. MacArthur cites in the Foreword that improved investment in palliative care in some countries which have legalised assisted suicide may be taking place, it is likely that as soon as the number of assisted suicide numbers become significant then the amount of money being invested in palliative care research would be reconsidered.

Equalities

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

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

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

8.1. Legalising assisted suicide would completely undermine the equality in value and worth of all lives in Scotland

Mr. MacArthur indicates that the Scottish Parliament has an "*opportunity to take the actions required to make sure that the end of life is more compassionate, fairer and more reflective of a dying person's choice. We have the ability to create a new standard for how we die*."[56]

However, the SCHB is extremely concerned with such a mistaken statement. It believes that legalising assisted suicide would certainly not develop a fairer society in which more compassion is present. Indeed, it is very important for society as a whole, to be very careful when crossing the bright red moral line of acknowledging that any life can become unworthy of life and should be ended. If it does, society may slowly become an ethical wilderness where the value of some human lives, such as those of persons with mental disability, is increasingly considered as being of poor or even substandard quality. It would also be a society where the value of a human life is purely relative and unequal – where it would be possible to grade the worth of every human life to reflect whether or not it is sufficiently useful, meaningful or pleasurable. And if a life does not reach a certain standard of worthiness, then this life can be ended either voluntarily or non-voluntarily. It would be a society that has lost its belief in the equal value of all human life.

Accordingly, legalising assisted suicide would mean that society would accept that some individuals can actually lose their inherent value and have lives which no longer have any worth or meaning. It would also mean denying the inherent value which is due to an individual, in order for him or her to be legally killed. In other words, it would give the message that the value of a human life is only based on subjective choices and decisions and whether this life meets certain quality standards.

8.2. Assisted suicide would undermine the protection due to the most vulnerable persons in society

Mr. MacArthur indicates that: "*Where assisted dying is legal the evidence shows that such laws are safe and effective.The safeguards outlined … would act to ensure that vulnerable people are not adversely affected within the boundaries of the present proposal*."[57] Adding: "*Arguably, the current law in Scotland does not*

[56] Assisted Dying for Terminally Ill Adults (Scotland) Bill Consultation, Liam McArthur MSP, Foreword.

provide adequate protection to vulnerable people. [58]

However, Mr. MacArthur is again gravely mistaken in this conclusion since, by legalising assisted suicide, some vulnerable people certainly will begin to see the procedure as a possible option for releasing family members, carers and the broader society from the responsibility of providing support. In other words, it may encourage them to believe that death is a greater good if they consider themselves to be a burden. The House of Lords Select Committee recognised this risk by indicating in 1994:

> "*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 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*." [59]

This means that, in a responsible and civilised society, vulnerable persons need to know that the state is committed first and foremost to their well-being, even if this does involve expenditure of time and money. The manner in which the weakest and most vulnerable members of society are treated reflects the true identity of a society because it reveals its core values.

Moreover, if a person accesses assisted suicide just to make things easier for the carers, this may have profound consequences on the carers themselves who may then believe that they are the reason for the person's death.

Sustainability

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

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

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

☐ ~~Yes~~
x No
☐ ~~Unsure~~

Please explain the reasons for your response.

9.1. Inherent human dignity is grounded on an interdependent society

A distinction should be made between inherent and non-inherent human dignity. In an interactive society, making a choice about the value of a life (even one's own) means making a decision about the value of other lives. As the past UK Supreme Court judge, Baroness Brenda Hale, indicated: "*Respect for the dignity of others is not only respect for the essential humanity of others; it is also respect for one's own dignity and essential humanity. Not to respect the dignity of others is also not to respect one's own dignity*."[60]

[57] Assisted Dying for Terminally Ill Adults (Scotland) Bill Consultation, Liam McArthur MSP, Para 2.5.

[58] Assisted Dying for Terminally Ill Adults (Scotland) Bill Consultation, Liam McArthur MSP, Para 2.5.

[59] House of Lords Select Committee Report on Medical Ethics, HL 21-I, 31 January 1994 - p 49, para 239.

[60] Brenda Hale, Dignity, Journal *of Social Welfare & Family Law.* Vol. 31, No. 2 (2009), pp. 101–108 (p.106).

But the reverse is also true: 'Not to respect one's own inherent dignity is not to respect the inherent dignity of others'. The senior lawyer, Patrick Devlin, indicates "*The reason why a man may not consent to the commission of an offence against himself beforehand or forgive it afterwards is because it is an offence against [civilised] society*."[61] In other words, persons who consider that their lives are no longer worth living or that they have lost their inherent dignity are, in a way, indirectly indicating that the lives of persons in similar or in worse situations are also not worth living and should be ended. It would mean that inherent human dignity is no longer inviolable or universal.

Similarly, persons who believe that their lives are no longer worth living or that they have lost their inherent dignity must reject the worth, value and meaning that others, such as their family, friends and even society, are recognising in their lives. In addition, for a person to consciously deny and reject the value, meaning and worth given by others to his or her life, without attenuating circumstances such as a psychological disorder, means rejecting these other persons' capacity to confer dignity which is tantamount to undermining their personhood.

As the House of Lords Medical Ethics Select Committee in 1994 indicated, belief in the special worth of human life is at the heart of civilised society. It is the fundamental value on which all others are based, and it is the foundation of both law and medical practice.[62] The prohibition of intentional killing is thus the cornerstone of the law and social relationships. It protects each individual impartially, embodying the belief that all are equal. Dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. This means that, with assisted suicide, the interests of the individual cannot be separated from the interest of society as a whole[63] - personal opinions about worth, meaning and value of human life matter to the whole of society.

Moreover, when society recognises that it is acceptable for one person to be willingly involved in the death of another, dangerous consequences are to be expected as to the way the whole of society considers the value, meaning and worth of human life.

Finally, with assisted suicide, as opposed to suicide, another person must believe that it would be preferable for the person who wishes to die not to continue living. In other words, assisted suicide, reflect the unacceptable belief by one person that another person has lost, or will lose, his or her value of life to such an extent that his or her life is not worth living, is meaningless, and should be ended.

General

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

10.1. Assisted suicide should not be legalised just because it is occurring in secret

Mr. MacArthur indicates in the Foreword: "*The barrier that the current law creates does not stop people taking action to control the end of their lives but instead drives the practice behind closed doors. This means potentially vulnerable people cannot be and are not being protected. In contrast, an assisted dying law would protect people by bringing these difficult decisions out into the open. It would introduce safeguards before a person could access an assisted death, and therefore provide both more protection and more choice than the current law allows.*" [64]

The SCHB believes, however, that if the law is to be changed by Members of Parliament to bring out into

[61] Devlin, P., The Enforcement of Morals, London, 1965, p. 6.

[62] House of Lords Select Committee Report on Medical Ethics, HL 21-I, 31 January 1994 - paragraph 34.

[63] House of Lords Select Committee Report on Medical Ethics, HL 21-I, 31 January 1994 - paragraph 237.

[64] Assisted Dying for Terminally Ill Adults (Scotland) Bill Consultation, Liam McArthur MSP, Para 2.5.

the open everything that is happening in secret, it would completely undermine the rule of law and civilised behaviour in a country. It would mean legalising and accepting anything that is completely unethical, such as murder! In addition, as reflected by the situation in Belgium, legalising assisted suicide does not diminish the number of illegal acts. This number may even increase because a certain leniency may develop in undertaking such acts.[65] In some circumstances, some confusion as to what can be considered as an act of assisted suicide seems to also exist.[66]

Finally, by prohibiting assisted suicide, it is possible to consider hard cases in which there is a measure of ambiguity, on a case by case basis, in an appropriate court of law and judged according to a good standard of fairness and compassion.

10.2. International legal instruments oppose assisted suicide

The belief in the inherent dignity and inviolability of human life is based on international globally accepted secular principles such as the ***United Nations' Universal Declaration of Human Rights.***

Mr MacArthur indicates that a prohibition on assisted suicide may be "*raising basic questions about whether it is compatible with Scotland's international obligations under the European Convention on Human Rights*."[67] However, the reverse is true since the ***Council of Europe Parliamentary Assembly Recommendation 1418 (1999) on the Protection of the human rights and dignity of the terminally ill and the dying***[68], which is one of the last legal texts of some substance on the issue, indicates in Article 9.c. that:

> *The Assembly therefore recommends that the Committee of Ministers encourage the member states of the Council of Europe to respect and protect the dignity of terminally ill or dying persons in all respects by upholding the prohibition against intentionally taking the life of terminally ill or dying persons, while:*
>
> *i. recognising that the right to life, especially with regards to a terminally ill or dying person, is guaranteed by member states, in accordance with Article 2 of the European Convention on Human Rights which states that "no one shall be deprived of his life intentionally";*
>
> *ii. recognising that a terminally ill or dying person's wish to die never constitutes any legal claim to die at the hand of another person;*
>
> *iii. recognising that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death.*

These texts emphasise the universal, absolute, inalienable nature of the concept of inherent human dignity. In other words, they support the notion that *no person* can lose his or her inherent human value, worth and dignity at any time in his or her life. To reject such a notion would not only seriously challenge the whole concept of inherent human dignity but would be an extremely serious precedent in a world that has fought so hard to recognise the same inherent value, worth and dignity in all persons.

10.3. Neither suicide nor assisted suicide should be seen as acceptable outcomes

Mr. MacArthur indicates in the Foreword that in the case of assisted suicide: "*The use of 'suicide' in this context is not appropriate, given that the person will only be able to request an assisted death if they have a terminal illness that will end their life i.e. the choice to live has already been taken away, the choice of an assisted death allows the inevitable dying process to be less traumatic*."[69] But again this is a very disingenuous statement since

[65] French National Consultative Ethics Committee for health and life sciences, The End of Life, Personal Autonomy, the Will to Die, 2013, p. 50.

[66] Agnes van der Heide et al., End-of-Life Practices in the Netherlands under the Euthanasia Act, *N Engl J Med* 2007; 356:1957-1965,

[67] Assisted Dying for Terminally Ill Adults (Scotland) Bill Consultation, Liam McArthur MSP, Para 2.1.

[68] Council of Europe Parliamentary Assembly Recommendation 1418 (1999), Protection of the human rights and dignity of the terminally ill and the dying, http://assembly.coe.int/documents/adoptedtext/ta99/erec1418.htm

[69] Assisted Dying for Terminally Ill Adults (Scotland) Bill Consultation, Liam McArthur MSP, Footnote 1.

the definition of suicide has always represented the action whereby a person takes his or her own life and it is important to not succumb to any form of meaning-manipulation or 'double-speak'. Moreover, it should be noted that nobody ever has the choice to live at the end of their lives.

In 2018, three US psychiatrists indicated that the practice of physician assisted suicide for psychiatric disorders is, in many cases, very difficult to distinguish from other forms of suicide. They argue that the features of 'traditional' suicide may indeed be present in cases of euthanasia for psychiatric disorders. The authors write: "*persons who receive psychiatric [Physician-Assisted Death] PAD share these characteristics [with persons who die by suicide]: they all have some form of mental illness; most also have personality disorders, have attempted suicide, and are socially isolated or lonely*".[70]

MacArthur also assumes that if assisted suicide is legalised for persons approaching death, then physicians will always get their prognosis wright which is not the case.

In addition, the attempted suicide of any individual, such as a young person, can never be seen as something to be encouraged in society. Instead, great concern should be raised regarding the individual's state of mind and the fact that he or she may need psychological assistance or counselling. It would be completely unethical to help someone commit suicide in these circumstances. As a result, it is difficult to consider how any form of assisted suicide can be considered.

Moreover, if assisted suicide was ever legalised it would mean that the suicide of individuals, such as healthy young persons, may eventually be considered as acceptable to society. This would happen at the same time as the Scottish government is trying to reduce the high suicide rates in some parts of the country with programmes such as ***Chooselife*** (www.chooselife.net).

Legalising assisted suicide would inevitably send the message that a disabled life has less value in society than a non-disabled one. Already in some countries, such as in Belgium, it is disabled people who are generally considered for assisted suicide. This only reinforces the stereotype that such people's lives are valueless, tragic, burdensome and insufferable.[71]

10.4. Impact of assisted suicide on suicide

Belgium has a suicide rate that is well above average for Europe (indeed the highest in Western Europe) and, while the suicide rate in Belgium decreased in the period 1995 to 2010, this decrease was smaller than the average decrease across Europe.[72] Research has also shown that, more generally, individuals living in countries with high suicide rates are generally more supportive of the idea of taking one's life than individuals from countries with relatively low suicide rates.[73] This may mean that in some circumstances, it may be possible for suicidal individuals to begin to believe that they are entitled to assisted suicide in order to end their lives. But if this happens, it would completely change the way a society considers any form of suicide. Instead of seeing such a prospect as a desperate situation which society should seek to prevent to the best of its ability it may begin to accept that all autonomous and rational persons have a right to end their lives, if they so wish and for any reason. As the American psychiatrist, Herbert Hendin, indicates: "*'Normalizing' suicide as a medical option lays the groundwork for a society that turns euthanasia into a "cure" for suicidal depression.*"[74]

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[70] Kim SYH, Conwell Y, Caine ED. Suicide and Physician-Assisted Death for Persons With Psychiatric Disorders: How Much Overlap? *JAMA Psychiatry.* 2018;75(11):1099–1100.

[71] A witness to the Canadian Senate Committee on Euthanasia and Assisted Suicide said: *"Canada has identified a suicide problem among its youth, and we have responded "How can we prevent it?" Canada has identified a suicide problem among Aboriginal peoples and we have responded "How can we prevent it?" Canada has identified a suicide problem among people with disabilities and we have responded "How can we assist them to kill themselves?"*
Keown, J. 2002. *Euthanasia, Ethics and Public Policy: An Argument Against Legislation.* Cambridge: Cambridge University Press, p. 280.

[72] OECD (2012), "Suicide", in Health at a Glance: Europe 2012, OECD Publishing. http://dx.doi.org/10.1787/9789264183896-10-en

[73] Steven Stack, Augustine J. Kposowa, The Association of Suicide Rates with Individual-Level Suicide Attitudes: A Cross-National Analysis, Social Science Quarterly, Volume 89, Number 1, March 2008, 39-59.

[74] Hendin H. Assisted suicide, euthanasia, and suicide prevention: the implications of the Dutch experience. Suicide Life Threat Behav. 1995 Spring;25(1):193-204.