Assisted Dying for Terminally Ill Adults (Scotland) Bill

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Consultation Document

Privacy Notice *

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

If you are under 12 years old and making a submission, we will need to contact you to ask your parent or guardian to confirm to us that they are happy for you to send us your views. Please ONLY tick this box if you are UNDER 12 years of age.
My answer: No

About you

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

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".) *
My answer: 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:
My answer:

Please choose one of the following: *
My answer: I am content for this response to be published and attributed to me or my organisation

If you have requested anonymity or asked for your response not to be published, please give a reason (Note: your reason will not be published):
My answer:

Please provide your Full Name or the name of your organisation.

(Note: the name will not be published if you have asked for the response to be anonymous or "not for publication". Otherwise this is the name that will be published with your response). *
My answer:

Please provide details of a way in which we can contact you if there are queries regarding your response. Email is preferred but you can also provide a postal address or phone number.
We will not publish these details.*
My answer:

Aim and Approach

Note: All answers to the questions in this section may be published (unless your response is “not for publication”).

1. Which of the following best expresses your view of the proposed Bill? *
My answer: Fully opposed

Please explain the reasons for your response.
My answer: Other nations demonstrate that once assisted suicide is legalised, a slippery slope begins, and eventually individuals with disabilities, mental illness and other chronic but non -life-threatening diseases, as well as minors, have access to assisted suicide. This is clear in common and civil law jurisdictions. Belgium (https://www.dw.com/en/belgium-approves-assisted-suicide-for-minors/a-17429423) and the Netherlands (https://www.bbc.co.uk/news/world-europe-54538288) have expanded their provision of assisted suicide and euthanasia to include children. Oregon (https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf) has expanded its list of applicable conditions to now include arthritis, complications from a fall, and kidney failure, among other non-terminal conditions. Assisted suicide is far from a fully autonomous decision. Suffering patients may choose assisted suicide out of a sense of responsibility to their families or communities rather than from a personal desire to die. It is common sense that legalising assisted suicide might encourage some patients to imitate the actions of their friends and relatives who undergo the procedure. Autonomy, then, becomes a form of abandonment. The latest reports from American states that have sanctioned assisted suicide demonstrate that vulnerable patients have sought to die for fear of burdening their families. For example, 51% of patients from Washington state in 2018 cited concerns (https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2018.pdf) that they would be a burden on their family, friends, and caregivers should they continue to live. Ultimately, these are existential rather than medically intractable issues. Licensing doctors to provide lethal drugs to patients is fundamentally different from withdrawing ineffective life-sustaining treatment, and crosses a Rubicon in medicine. The role of doctors is to support patients to live as well, and as comfortably, as possible until they die, not to deliberately bring about their deaths. The possibility of misdiagnosis and non-medical pressures on a patient to end their own lives demonstrates the difficult position such legislation would place doctors in. Society should not allow a double standard in seeking to allow some people assistance in suicide, even as we do all we can to prevent young people and other vulnerable groups from committing suicide. The ‘right to die’ can easily become the ‘duty to die’ as the suicides of the elderly and infirm become normalised. Dutch ethicist Professor Theo Boer (a former proponent of assisted suicide who changed his position after reviewing thousands of cases of euthanasia) has noted (https://www.dailymail.co.uk/news/article-2686711/Dont-make-mistake-As-assisted-suicide-bill-goes-Lords-Dutch-regulator-backed-euthanasia-warns-Britain-leads-mass-killing.html): “‘Pressure from relatives, in combination with a patient’s concern for their wellbeing, is in some cases an important factor behind a euthanasia request. Not even the review committees, despite hard and conscientious work, have been able to halt these developments.’”

2. Do you think legislation is required, or are there other ways in which the Bill's aims could be achieved more effectively?
Please explain the reasons for your response.
My answer: No, legislation to introduce assisted suicide to Scotland is not required. A better alternative would be to invest in the provision of palliative care services and to increase awareness around the current choices around end-of-life care already available in Scotland. There is no legal prohibition against refusing or discontinuing life-extending treatment. Doctors may treat us only with our consent. Terminally ill patients who wish to let their illness take its course without further treatment are at liberty to do so. And, if they do so, their doctors have a duty of care to provide relief of pain or other distress. It is not true that terminally ill people are forced by the law to suffer. There is a 'right to die'. What there is not is a right to be killed. It's the difference between accepting death and seeking death. The possibility of prosecution for assisted suicide both protects vulnerable people from abuse, such as the elderly, infirm, and those with disabilities, and provides for discretion on compassionate grounds. Both euthanasia and assisted suicide are effectively outlawed (https://archive2021.parliament.scot/parliamentarybusiness/report.aspx?r=9717&mode=pdf) in Scotland. Suspected cases of assisted suicide or euthanasia can be treated under homicide law, but the Crown Office and Procurator Fiscal Service has not prosecuted (https://archive2021.parliament.scot/parliamentarybusiness/report.aspx?r=9717&mode=pdf) a case of assisted suicide since 2006. Arguments that assisted suicide is an essential part of end-of-life care misrepresent the current end-of-life care options available to UK patients. Advance Directives (https://www.macmillan.org.uk/cancer-information-and-support/treatment/if-you-have-an-advanced-cancer/advance-care-planning/advance-directive#:~:text=am%20to%205pm) already allow patients to reject life-sustaining treatments in advance. Similarly, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders already allow (https://www.macmillan.org.uk/cancer-information-and-support/treatment/if-you-have-an-advanced-cancer/advance-care-planning/advance-directive#:~:text=am%20to%205pm) patients to choose not to be resuscitated at the end of their life. In 2019, 42 Britons travelled to Dignitas for an "accompanied suicide", according to the Swiss clinic's own figures (http://www.dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2019.pdf). Though tragic, this small number was equivalent to around 0.007% of all deaths (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregistrationsummarytables/2019) in Britain (https://www.gov.scot/publications/foi-202000128465/#:~:text=2017%20(full%20year)%20%2D%2057%2C872,2019%20(full%20year)%20%2D%2057%2C691) in the same period. Polling of public support for assisted suicide is flawed, and produces more complicated results than is often covered in the media. More precise questions lead to a dramatic drop in support for legal change. For example, in February 2019, when asked (https://2sjjwunnql41ia7ki31qqub1-wpengine.netdna-ssl.com/wp-content/uploads/2019/02/Care-Not-Killing-Assisted-Suicide-Poll-Feb-2019-updated.pdf) if they "'would be concerned that some people would feel pressurised into accepting help to take their own life so as not to be a burden on others' if assisted suicide were legal," 47% of Scottish respondents said yes and only 32% disagreed. Similarly, 48% agreed (https://2sjjwunnql41ia7ki31qqub1-wpengine.netdna-ssl.com/wp-content/uploads/2019/02/Care-Not-Killing-Assisted-Suicide-Poll-Feb-2019-updated.pdf) that "if GPs are given the power to help patients commit suicide it will fundamentally change the relationship between a doctor and patient, since GPs are currently under a duty to protect and preserve the lives of patients", while only 28% disagreed.

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

Please explain the reasons for your response, including if you think there should be any additional measures, or if any of the existing proposed measures should be removed. In particular, we are keen to hear views on Step 2 - Reflection period, and the length of time that is most appropriate.
My answer: No assisted suicide law can ever be a safe law. Evidence from overseas demonstrates that, incrementally but inevitably, the 'right to die' extends from 'hard cases' to a more holistic provision, despite the best intentions of those arguing in favour of regulated mild reform. An assisted suicide law, however well-intended, would alter society's attitude towards the disabled, suggesting that assisted suicide is an option they 'ought' to consider. Canada has been criticised (https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=24481&LangID=E) by successive (https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26687) UN special rapporteurs for a "growing trend to enact legislation enabling access to medically assisted dying based largely on having a disability or disabling conditions, including in old age." All major UK disability rights groups oppose assisted suicide (such as Disability Rights UK (https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26687), SCOPE (https://www.scope.org.uk/media/press-releases/scope-concerned-by-reported-relaxation-of-assisted-suicide-guidance/), United Kingdom's Disabled People's Council (https://www.carenotkilling.org.uk/links/the-united-kingdoms-disabled-peoples-council-ukdpc/), and Not Dead Yet UK (http://notdeadyetuk.org/)). The lack of mandatory psychological assessment as part of the application for assisted suicide in other international jurisdictions, especially the American states, seems to contrast with the understanding that suicidal ideation should be treated as an instance of psychological distress. This may be failing those vulnerable patients who experience fleeting desires to die and require psychological care rather than assisted suicide. For instance, only five mental health provider's confirmations were received for a total of 508 cases of assisted suicide over four years under the End of Life Option Act in Colorado, USA (https://drive.google.com/file/d/1zJClMv9bSMIJjrE_YoDhSeSNh98qsnDq/view). A study of suicide rates in American states that have legalised assisted suicide has illustrated that legalisation is associated with an increase rather than a reduction in the total suicide rate (https://drive.google.com/file/d/1zJClMv9bSMIJjrE_YoDhSeSNh98qsnDq/view). The Dutch ethicist and former member of one of the five Regional Review Committees on Euthanasia in the Netherlands between 2005 and 2014 where he reviewed over 4,000 cases, Professor Theo Boer, who formerly supported assisted suicide, pleaded to the UK Parliament not to pass Lord Falconer's assisted suicide bill in July 2014. Dr Boer commented (https://www.dailymail.co.uk/news/article-2686711/Dont-make-mistake-As-assisted-suicide-bill-goes-Lords-Dutch-regulator-backed-euthanasia-warns-Britain-leads-mass-killing.html) that "In 2007 I wrote that 'there doesn't need to be a slippery slope when it comes to euthanasia . . . But we were wrong - terribly wrong . . . Whereas the law sees assisted suicide and euthanasia as an exception, public opinion is shifting towards considering them rights, with corresponding duties on doctors to act." We must avert the legalisation of assisted suicide which will incrementally but inevitably extend from 'hard cases' to a more holistic provision, despite the best intentions of those arguing in favour of regulated mild reform (https://philpapers.org/rec/KEOEEA). Such change would fundamentally alter the relationship between physicians and patients by introducing suicide as an acceptable mode of medicine. The Dutch ethicist, Professor Theo Boer, summarises the issue well: 'Whereas assisted dying in the beginning was the odd exception, accepted by many —including myself — as a last resort [. . .] [P]ublic opinion has shifted dramatically toward considering assisted dying a patient's right and a physician's duty' (https://adflegal.blob.core.windows.net/international-content/docs/default-source/default-document-library/resources/white-papers/a5-book_euthanasia-ebook-finalc.pdf?sfvrsn=2).

4. Which of the following best expresses your views of the safeguards proposed in section 1.1 of the consultation document?
My answer: Fully opposed

Please explain the reasons for your response.
My answer: Society should not allow a double standard in seeking to allow some people assistance in suicide, even as we do all we can to prevent young people and other vulnerable groups from committing suicide. A 2014 article (https://www.wweek.com/portland/article-22574-penalized-by-the-death-penalty.html) raised concerns about the availability of assisted suicide drugs in Oregon as they are also used in executions by lethal injection. In Oregon (https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf), often referenced as an exemplary case study of moderate reform, there has been an almost fifteen-fold increase in the number of deaths from lethal prescriptions from its inception in 1998 to 2020, including a 28% increase from 2019 to 2020 alone. In Switzerland, figures (https://www.bfs.admin.ch/bfs/de/home/aktuell/neue-veroeffentlichungen.assetdetail.11348852.html) from December 2020 (https://www.bfs.admin.ch/bfs/de/home/aktuell/neue-veroeffentlichungen.assetdetail.14966044.html) show the number of assisted suicides continues to increase annually, from 187 cases in 2003 to 1176 cases in 2018. This represents around a 529% increase in fourteen years since 2003. Belgium (https://www.dw.com/en/belgium-approves-assisted-suicide-for-minors/a-17429423) and the Netherlands (https://www.bbc.co.uk/news/world-europe-54538288) have expanded their provision of assisted suicide and euthanasia to include children. The American state of Oregon has expanded its list of applicable conditions to now include arthritis, complications from a fall, and kidney failure, among other non-terminal conditions (https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf). So-called safeguards cannot provide safety from the dangerous and damaging normalisation of suicide. The existing law focuses on the facts of what has happened in any case of assisted suicide. This is different from the proposed regime, whereby requests for lethal drugs would be assessed by a minority of doctors who are supportive of such practices and who in many cases would never have met the applicant before and would be ill-placed to make the social judgements (e.g. a settled wish to die, freedom from pressure) which form an important part of the assessment process envisaged. The existing law rests on a widely-supported and rational boundary – that we do not as a society aid and abet the suicides of others. Once that natural boundary is weakened by the introduction of arbitrary exceptions – such as terminal illness – it becomes just a line in the sand, easily crossed and hard to defend. Such laws contain within themselves the seeds of their own expansion.

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

Please explain the reasons for your response, including whether you think this should be a new or existing body (and if so, which body) and what data you think should be collected.
My answer: In the event of the legalisation of assisted suicide, it would be imperative to form a new statutory body that would be held responsible, alongside the Chief Medical Officer, for collecting, reviewing, and reporting data on the practice of assisted suicide to the highest possible standard. However, there are serious concerns as to the likelihood of such a body working effectively given the

inadequate data collection practices in other jurisdictions where assisted suicide has been legalised. The Chief Medical Officer must monitor the operation of the Act, including compliance with its provisions and any regulations or code of practice made under it, which should include, as a minimum. detailed data covering the criteria and how they were made within the act from medical information and the court decision, any reports on capacity and mental health assessments, and details of any drug problems. In sum, such data collection should cover at least all of the parameters of the Death With Dignity Act Annual Reports published by the Oregon Health Authority. These details should be recorded for at least 10 years to allow for thorough examination of trends, unforeseen developments, or complications. The Chief Medical Officer would then be responsible for publishing a report, at least annually, from the data gathered by the new statutory body on the operation of the Act. There should be further full reviews of the Act after two and five years of operation, respectively, and whenever trends emerge that indicate the operation of the Act has moved beyond the principles of its enactment. Concerningly, Oregon statute does not define participation under the DWDA as suicide. Instead, the Oregon Health Authority recommends that physicians record the terminal illness as the cause of death and the death as 'natural' (https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/faqs.aspx#deathcert). Any recording and reporting of data on assisted suicide should treat the cause of death as suicide, since it is the deliberate intervention to end the life of a person, rather than the passage of life and death through natural means. Despite attempts to accurately monitor the practice of assisted suicide in Oregon, a 2005 study (https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.162.6.1060?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed) found that one particular patient was issued with a lethal prescription nearly two years before he actually died of natural causes after receiving compassionate care instead. A further concern in relation to the possibility of accurately recording and reporting data on the practice of assisted suicide, and particularly in relation to complications, is that the prescribing physician has been present at only 14.6% of deaths from assisted suicide in Oregon since 1998 (https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf).

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

My answer: When considering the issue of conscientious objection, it must be emphasised that those medical professionals who are more involved in end-of-life care are less likely to support the legalisation of assisted suicide. According to a recent British Medical Association survey of its members, only 36% of doctors would be willing to participate (https://www.bma.org.uk/media/3367/bma-physician-assisted-dying-survey-report-oct-2020.pdf) in prescribing drugs for assisted suicide, while 45% of doctors would not be willing to participate. Any provision for conscientious objection must allow those objecting to abstain from referring a patient seeking assisted suicide to an able and willing medical professional. As argued by Roger Trigg, Emeritus Professor of Philosophy at the University of Warwick, in an article (https://pubmed.ncbi.nlm.nih.gov/27934565/) in the Cambridge Quarterly of Healthcare Ethics, "Even referring a patient to someone else, when what is in question may be assisted suicide, or euthanasia, seems to involve some complicity [...] Physicians and others should not be coerced into involvement of any kind in what they regard as wrong. Such coercion goes against the very principles of liberal democracy." It is, therefore, deeply concerning to read that this proposal (https://www.parliament.scot/-/media/files/legislation/proposed-members-bills/assisted-dying-for-terminally-ill-adults-scotland-consultation-2021-final.pdf) for legalising assisted suicide would insist that "a referral to another consenting doctor should be made if the initial doctor declined to assist the patient because of their personal beliefs." By still requiring an objecting doctor to provide an effective

referral, thereby involving them in the delivery of assisted suicide to the patient, the proposal does not adequately respect the moral concern of the objecting doctor about the practice of assisted suicide, which is clearly of substantial moral weight as a matter of life or death. In March 2020, the Physicians' Alliance Against Euthanasia reported (https://alexschadenberg.blogspot.com/2020/03/press-release-growing-number-of.html) that a growing number of physicians are being bullied into participating in the provision of euthanasia or assisted suicide. Palliative care specialists have suffered particular distress, including the "betrayal of collegial relationships", which should be of deep concern to anyone considering introducing assisted suicide. Worryingly, a British Columbia hospice society (https://www.cbc.ca/news/canada/british-columbia/bc-hospice-legal-funding-cut-province-1.5477556) has been embroiled in political and legal battle (including the removal of material support from their local health authority) for refusing to comply with provincial policies on medical assistance in dying which conflicted with its Christian character.

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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:
My answer: some reduction in costs

Please indicate where you would expect the impact identified to fall (including public sector bodies, businesses and individuals etc). You may also wish to suggest ways in which the aims of the Bill could be delivered more cost-effectively.
My answer: From the experience of the jurisdictions where assisted suicide has been legalised, it seems likely to lead to some reduction in costs given that it will replace proper, but costly, end-of-life care for such individuals. Licensing doctors to provide lethal drugs to patients is not simply another form of treatment and crosses a Rubicon in medicine by sanctioning suicide as a form of healthcare. Any cost-benefit analysis of assisted suicide compared to expenditure on other forms of healthcare is flawed in principle. Abandoning ill patients to assisted suicide rather than providing life-sustaining treatment cannot be seen as cost-effective no matter how relatively inexpensive it might be, since it cannot be measured as another form of medicine and analysed on the same terms. There should be deep concern that putting an economic "valuation" on individual human life could lead to treatment being refused for some individuals due to the lack of economic returns. In Canada, Roger Foley (https://www.ctvnews.ca/health/barely-hanging-on-to-life-roger-foley-shares-his-fight-for-home-care-with-un-envoy-1.4378334), an individual from Ontario who required expensive care but wanted to live 'was offered, among other things, medically assisted death'. Stephanie Packer, who was diagnosed with a terminal illness, said the company denied (https://www.insurancebusinessmag.com/us/news/breaking-news/insurer-offers-to-pay-for-assisted-suicide-but-not-chemotherapy-39441.aspx) her coverage for her treatments but offered to pay for assisted suicide after California passed a law allowing the measure in June 2016. We can expect that demand for assisted suicide would increase following its legalisation, and that the demand for proper, though costly, healthcare would decrease. For example, the latest report (https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf) from Oregon for 2020 showed around 28% increase in the number of deaths from assisted suicide from 2019, which is fifteen times more than the number of deaths when it was first introduced in 1998. Similarly, the second annual report (https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying/annual-report-2020/annual-report-2020-eng.pdf) on assisted suicide legislation in Canada for 2020 showed an increase in deaths of 34.2% over 2019, which represented 2.5% of all deaths in Canada in 2020. From 2016 to 2020, there was a total increase (https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying/annual-report-2020/annual-report-2020-eng.pdf) of 646% in such deaths. Legalising assisted suicide could lead to decreased investment in the vital care

of those living with disabilities who could become eligible for assisted suicide instead. As noted (https://hansard.parliament.uk/Lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL)?highlight=simple%20fact#contribution-ADE5F199-9BA7-4129-8FE6-AD5F32C3ECF2) by the disabled peer Lord Shinkwin during the Second Reading debate on the Assisted Dying Bill [HL] last October, “It is a simple fact that keeping those of us with severe disabilities alive costs money—lots of it”. Lord Shinkwin told (https://hansard.parliament.uk/Lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL)?highlight=simple%20fact#contribution-ADE5F199-9BA7-4129-8FE6-AD5F32C3ECF2) Parliament that, had assisted suicide become law, he would have “felt like a burden. If I had known then what we know now about the highly relevant assisted dying developments in Canada, I would have felt that a price had been placed on my head”. Although the legalisation of assisted suicide may well cut costs in this regard, such financial saving would come at the much steeper cost of social and medical failure to properly cater for the needs of those living with disabilities.

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?

My answer: Negative

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

My answer: The legalisation of assisted suicide would have a profoundly negative impact on the equal treatment of those living with disabilities, particularly if their condition is considered terminal under this proposed legislation. Laws send social messages. An assisted suicide law, however well-intended, would alter society’s attitude towards those living with disabilities, sending the subliminal message that assisted suicide is an option they ‘ought’ to consider, particularly if their condition is considered to be terminal. It cannot be ignored that all major disability rights groups in the United Kingdom (including Disability Rights UK (https://www.disabilityrightsuk.org/news/2015/september/our-position-proposed-assisted-dying-bill) , SCOPE (https://www.scope.org.uk/media/press-releases/scope-concerned-by-reported-relaxation-of-assisted-suicide-guidance/) , United Kingdom's Disabled People's Council (https://www.carenotkilling.org.uk/links/the-united-kingdoms-disabled-peoples-council-ukdpc/) , and Not Dead Yet UK (http://notdeadyetuk.org/)) oppose any change in the law. Disability advocates, including the Council of Canadians with Disabilities, have condemned (https://cacl.ca/2019/10/04/advocates-call-for-disability-rights-based-appeal-of-the-quebec-superior-courts-decision-in-truchon-gladu/) the 2019 ruling of the Quebec Superior Court to allow for assisted suicide in cases when death is not “reasonably foreseeable”. They have argued (https://cacl.ca/2019/10/04/advocates-call-for-disability-rights-based-appeal-of-the-quebec-superior-courts-decision-in-truchon-gladu/) that the decision risks sending the message that “having a disability is a fate worse than death”. We must learn from the example of Canada, which has been criticised (https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=24481&LangID=E) by successive (https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26687) United Nations special rapporteurs on the rights of persons with disabilities for the impact of its ‘medical assistance in dying’ law on persons with disabilities.

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?
My answer: No

Please explain the reasons for your response.
My answer: Legalising assisted suicide cannot ensure a strong, healthy, and just society nor can it ensure that policy is developed on the basis of strong scientific evidence. A study (https://europepmc.org/article/med/26437189) of suicide rates in American states that have legalised assisted suicide has illustrated that legalisation is associated with an increase rather than a reduction in the total suicide rate. Indeed, an Oregon Health Authority press release (https://www.oregon.gov/oha/ERD/Pages/NewCDCDataShowsSuicideLeadingCauseDeathAmongOregonYouth2018.aspx) from March 2020 announced that "suicide continues to be a concerning problem in Oregon across all age groups, including youths". Neglecting alternative pathways out of difficult situations that might cause someone to seek assisted suicide seems to be a failure of compassion. As Fiona Bruce MP has argued (https://www.huffingtonpost.co.uk/fiona-bruce/assisted-dying-bill_b_8132750.html), "dependency on others and interdependency with others are part and parcel of life from birth on, at different stages, for us all [...] no one should feel that at a stage when they are depending on others, they should consider ending their life prematurely". Society should not allow a double standard in seeking to allow some people assistance in suicide, even as we do all we can to prevent young people and other vulnerable groups from committing suicide. No country would countenance youth suicides as solely an issue of individual freedom, so nor should it countenance the suicides of those living with terminal illnesses as being simply a question of autonomy. There is no 'right to die' in international law and there is no international obligation on Scotland to legislate for assisted suicide or euthanasia. Case law from the European Court of Human Rights (ECtHR) has clarified that there is no 'right to die'. In Pretty vs United Kingdom 2002, the ECtHR ruled that "no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 [of the Convention]" (http://hudoc.echr.coe.int/fre?i=003-542432-544154). Moreover, "[t]he Court did not consider that the blanket nature of the ban on assisted suicide was disproportionate" (http://hudoc.echr.coe.int/fre?i=003-542432-544154).

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)?

My answer:
