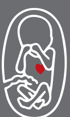
SPUC guide to responding to the consultation by Liam McArthur MSP on the proposed Assisted Dying for Terminally Ill Adults (Scotland) Bill



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About this guide

A public consultation has been launched on a bill proposed by Liam McArthur MSP to legalise assisted suicide in Scotland.

This briefing is intended to help you respond to the consultation, and to give suggestions about answering the questions.

It is important that as many people as possible respond to this consultation. We must send a strong message to Mr. McArthur, MSPs and the Scottish Government: that assisted suicide is a dangerous and unethical practice that must never be legalised in Scotland or any other part of the UK.

The consultation is running until Wednesday 22 December 2021. Please complete the questionnaire as soon as you can and encourage others to do the same.

Background to the consultation

On 22 September 2021, Liam McArthur, the Scottish Liberal Democrats MSP for the Orkney Islands, submitted a proposal for a bill "to enable competent adults who are terminally ill to be provided at their request with assistance to end their life". As is usual practice with Members' Bills in the Scottish Parliament, Mr. McArthur is now consulting the public for three months. The consultation process is being supported by the Scottish Parliament's Non-Government Bills Unit (NGBU), which will analyse and provide an impartial summary of the responses received.

Following the consultation, Mr. McArthur will need the support of 18 MSPs to introduce the bill. Once introduced, a Member's Bill follows a three-stage scrutiny process, during which it may be amended or rejected outright.

This proposed bill is part of a big push by the assisted suicide lobby. There is also a bill before the House of Lords in Westminster. If assisted suicide is legalised in any part of the UK, it will have massive repercussions for the whole country.

What does the Bill propose?

The purpose of the bill is to "enable competent adults who are terminally ill to be provided at their request with assistance to end their life". Death would be brought about "by means of medication provided by a doctor for that purpose". Mr. McArthur objects to calling this "assisted suicide", preferring the term "assisted dying". However, "assisted dying" is a campaigning term, with no meaning in law. We use "assisted suicide" throughout this briefing.

The key features of the proposal are:

- The person who has a terminal illness would sign a declaration in front of two independent witnesses that they wish to end their life. It must be signed by the attending doctor and another doctor.
- A "registered healthcare practitioner" (which, the consultation document states, includes nurse practitioners) must deliver the life-ending drugs and be present when the person takes them.
- A person would be eligible for death if they were considered terminally ill for the purposes of providing social security. Under this definition, terminal illness applies to those who are deemed by doctors as "unable to recover", regardless of the time they have left to live.
- The proposal acknowledges the importance of medical practitioners being able to conscientiously object to taking part in an assisted suicide process, but "if the Bill becomes law it would be the patient's legal right to request assistance, and a referral to another consenting doctor should be made if the initial doctor declined to assist the patient because of their personal beliefs".

Who can respond to the consultation?

Any member of the public can respond to this consultation. There are also options to tick for professionals/academics with relevant experience.

How do I respond to the consultation?

Online survey

You are encouraged to submit your response via an online survey (Smart Survey) if possible, as this is quicker and more efficient both for you and the Parliament.

To respond via the online survey, please follow this link: https://www.smartsurvey.co.uk/s/AssistedDyingProposal/

Electronic or hard copy submissions

Responses not made via Smart Survey should, if possible, be prepared electronically (preferably in MS Word). Please keep formatting of this document to a minimum. Please send the document by email (as an attachment, rather than in the body of the email) to: Liam.McArthur.msp@parliament.scot

Responses prepared in hard copy should either be scanned and sent as an attachment to the above email address or sent by post to:

Liam McArthur MSP
Scottish Parliament
Edinburgh
EH99 1SP

Guidance on answering questions

Please note:

1. We have reproduced the questions from the consultation in the following boxes.

2. We have made suggestions for comments. Please put your comments in your own words.

3. Please include your own personal or professional experience and/or your own thoughts in your comments.

Please fill in the "About You" questions as appropriate.

Aim and approach

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

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

Please explain the reasons for your response.

Select "fully opposed". Points you could include in your comments:

Assisted suicide puts pressure on vulnerable people.

Offering people the choice to end their lives creates pressure for them to choose death. Where assisted suicide is legal, one reason people choose to die is that they feel they are a burden on others.

- In Oregon in 2020, a majority (53.1%) of people killed by assisted suicide cited a fear of being a "burden on family, friends/caregivers" as a reason to end their lives.[1]
- In Washington State in 2018, 51% of people who were killed by assisted suicide said that being a burden on family, friends and caregivers was a reason to end their lives.[2]

In one study, researchers also identified a range of pressures on vulnerable people who desire assisted suicide, leading to a choice "strongly influenced by fears, sadness and loneliness". The researchers were concerned about the development of a culture that would "increase social pressure on older people and reinforce negative ideas surrounding old age".[3]

It is estimated that between 7% and 9% of older people in Scotland are victims of at least one form of abuse, with over 40% of victims suffering more than one kind of abuse.[4] A recent report found that more than a third of older people in Scotland feel that they are a burden to society, while 34% felt that life was getting worse for older people.[5] In such an atmosphere, older people are vulnerable to feeling pressured to end their lives prematurely.

[1] Oregon Death with Dignity Act 2020 Data Summary

[2] 2018 Death with Dignity Act Report (July 2019)

[3] van Wijngaarden E., et al. (2017) "Assisted dying for healthy older people: a step too far?" BMJ 357:2298.

[4] https://www.ageconcernscotland.org.uk/elder-abuse/

[5] Age Scotland, The Big Survey 2021, https://www.ageuk.org.uk/globalassets/age-scotland/documents/policy-and-research/high-4967-scotinfrom-age-scotland-big-survey---full-report.pdf [accessed 11 October 2021]

Disabled people fear assisted suicide.

People with disabilities particularly fear a change in the law which could make them feel pressured to end their lives.

Proponents of "assisted dying" insist that it is not about disability. However, while people with disabilities are not usually terminally ill, the terminally ill are almost always disabled.[6] Although intractable pain has been emphasised as the primary reason for enacting assisted suicide laws, the top five reasons Oregon doctors actually reported for issuing lethal prescriptions were:

- "loss of autonomy" (91%)
- "less able to engage in activities" (89%)
- "loss of dignity" (81%)
- "loss of control of bodily functions" (50%)
- "feelings of being a burden" (40%)[7]

These are disability issues. Common views still found in society – for example, that people with disabilities have pitiful lives and must find day-to-day existence terrible – unfortunately inform popular discussions about assisted suicide. In this climate, the fears of disabled people, including fears for others more recently disabled who receive such negative messages from society, must not be dismissed.

Our response to disability should be to offer empathy and practical help as needed, not to make disabled people feel they ought to choose death.

The establishment of assisted suicide as clinical and public policy will reinforce social conditions that contribute to some disabled people's despair.[8]

Assisted suicide cannot be controlled.

The arguments used for assisted suicide are essentially the same as for euthanasia, and will in time be used to apply pressure for euthanasia. In countries where assisted suicide and euthanasia are both legal, vulnerable groups, including children, infants, dementia patients, psychiatric patients, those who are not dying, and those who have not requested euthanasia, have over time all received euthanasia and assisted suicide. In Dutch and Belgian reports up to 2010, between 7% and 9% of all infant deaths involved active euthanasia, that is, a lethal injection. More recent reports almost certainly underestimate the rate because practitioners fail to report cases, some of which they considered not to be euthanasia, even though a lethal injection was used.[9] In the Netherlands, the number of people with dementia killed by euthanasia has risen steadily from 12 in 2009 to 162 cases in 2019.[10]

Oregon is often held up a good example by "assisted dying" campaigners who claim that "there have been no cases of abuse in Oregon's law". However, the State does not collect adequate data to be able to make this claim. Data on assisted deaths in Oregon come from a form filled out by the physician *who wrote the lethal prescription*. And in the first decade of legalisation, one quarter (62,271) of all lethal prescriptions were provided by just three doctors.[11] Also, the number of cases of assisted suicide in Oregon has steadily increased year on year from 16 in 1998 to 188 in 2019, an increase of 1175%.[12]

Assisted suicide is not the answer to pain.

Assisted suicide is not a solution to pain. Good palliative care should ensure that pain is well controlled. Research suggests that palliative care can significantly improve quality of life, with people experiencing

[6] https://notdeadyet.org/disability-rights-toolkit-for-advocacy-against-legalization-of-assisted-suicide

[7] Oregon Death with Dignity Act 2020 Data Summary

[8] Gill C.J. (2010) "No, we don't think our doctors are out to get us: Responding to the straw man distortions of disability rights arguments against assisted suicide." *Disability & Health* J 3:31-38.

[9] Gregory K. Pike (2020). "Euthanasia and Assisted Suicide – When Choice is an Illusion and Informed Consent Fails."

[10] Regional Euthanasia Review Committees RTE Annual Report 2019 https://english.euthanasiecommissie.nl/the-committees/documents/ publications/annual-reports/2002/annual-reports/annual-reports

[11] From <https://blogs.bmj.com/bmj/2018 (Web view)

[12] Oregon Health Authority, Public Health Division (2020) Oregon Death With Dignity Act: 2019 Data Summary. See https://www.oregon.gov/

fewer physical symptoms[13] and reduced rates of depression.[14] Legalising assisted suicide risks less investment being made in palliative care.

Doctors oppose assisted suicide.

Doctors have historically been opposed to both euthanasia and assisted suicide. The majority of doctors in the UK remain opposed to assisted dying. The opposition to euthanasia is strongest amongst doctors who work most closely with dying patients and are most familiar with treatments available. 82% of members of the Association for Palliative Medicine of Great Britain & Ireland rejected the legalisation of assisted suicide when last polled[15], and the Royal College of General Practitioners (RCGP)[16] and the British Geriatrics Society[17] remain opposed to euthanasia.

Suicide rates go up.

In countries with assisted suicide, there is evidence of a rise in suicide more broadly. A 2015 study looking at the United States found that making it legal for doctors to assist someone to end their life resulted in a 6.3% increase in total suicides, and a 14.5% increase for those over 65 years of age.[18]

The report's authors concluded that changing the law was associated with "an increased inclination to suicide in others". This implies that changing the law to allow assisted suicide has engendered a cultural change. Suicide in those U.S. states that legalised it now seems to be viewed as more acceptable.

Suicide is rightly seen as a profound tragedy, and the community wants to help people see their lives as worth living. Legalising assisted suicide undermines community efforts to combat suicide more generally and risks abandoning the frail and vulnerable right at the time they should be supported most.

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

Legalising assisted suicide means that some people who say they want to die will receive suicide intervention, while others will receive suicide assistance. The difference between these two groups of people will be their health or disability status, leading to a two-tiered system that results in death for the socially devalued group.[19]

Assisted suicide does not result in greater patient autonomy.

The evidence indicates that patient autonomy is too susceptible to external influences to provide robust protection for vulnerable groups such as the elderly, infirm or disabled. In practice, personal autonomy is not a decisive factor for Dutch physicians when they euthanise their patients.

> This is supported by the finding that 1000 people actually had their lives terminated without an explicit request. In many cases, it is the condition of the patient, not the request, which is the real ground for euthanasia...[20]

This has been the experience of the Netherlands.

> Paradoxically, the jurisprudential "legality" of euthanasia that was fought for by advocates of voluntary euthanasia on the basis of the principle of autonomy and self-determination of patients, actually has increased the paternalistic power of the medical profession above its last limit, above the law.[21]

[13] Higginson I. J., Bausewein C., Reilly C. C., Gao W., Gysels M., Dzingina M., McCrone P., Booth S., Jolley C. J., Moxham J. "An integrated palliative and respiratory care service for patients with advanced disease and refractory breathlessness: a randomised controlled trial." Lancet Respir Med. 2014 Dec;2(12):979-87. DOI: 10.1016/S2213-2600(14)70226-7. Epub 2014 Oct 29. PMID: 25465642.

[14] Temel, Jennifer & Greer, Joseph & Muzikansky, Alona & Gallagher, Emily & Admane, Sonal & Jackson, Vicki & Dahlin, Constance & Blinderman, Craig & Jacobsen, Juliet & Pirl, William & Billings, John & Lynch, Thomas. (2010) "Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer." The New England journal of medicine. 363. 733-42. 10.1056/NEJMoa1000678.

[15] https://apmonline.org/news-events/apm-physician-assisted-dying-web-materials/

[16] https://www.bgs.org.uk/policy-and-media/physician-assisted-suicide

[17] https://www.rcgp.org.uk/policy/rcgp-policy-areas/assisted-dying.aspx

[18] Jones D. A., Paton D. "How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?" South Med J. 2015 Oct;108(10):599-604. DOI: 10.14423/SMJ.0000000000000349.PMID: 26437189

[19] Coleman D. (2002) Not Dead Yet. In: *The Case against Assisted Suicide. For the Right to End-of-Life Care*. Eds Foley K & Hendin H, John Hopkins University Press, Baltimore, 221.

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

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

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.

Points you could include in your comments:

- Legislation is not required, as the aims of the bill are unethical and dangerous.
- The primary aim of the bill, providing terminally ill patients with lethal drugs to assist their suicide, should not be contemplated in a civilised society.
- This Bill crosses a Rubicon that will damagingly change the culture of dying in Scotland and the wider UK forever, and most importantly, change how the vulnerable are viewed and treated.
- Far from lacking oversight, current Scottish law offers a far greater level of protection than that provided in any assisted suicide legislation enacted to date. At present, anyone who assists another person to commit suicide will know that manipulative behaviour or criminal motivation could be uncovered by an investigation. The McArthur Bill, however, offers no significant deterrent for someone seeking to exert an improper influence on a vulnerable person.
- Ensuring that people do not suffer "a prolonged and painful death" (one of the aims behind the bill) is not best achieved through legalising assisted suicide. Uncontrollable pain was not even in the top five reasons that people in Oregon gave for choosing assisted suicide.[22] Assisted suicide is not the solution to pain. Good palliative care should ensure that pain is controlled well. Research suggests that palliative care can significantly improve quality of life – with people experiencing fewer physical symptoms[23] and reduced rates of depression[24]. In addition, there is little evidence that assisted death is quick and painless. Experts writing in the BMJ point out that "The safety and efficacy of previous and current oral assisted dying drug combinations is not known" and that reported adverse effects of drug combinations used to induce death "include vomiting, myoclonus and a prolonged dying process of up to 47 hours."[25] Dr. Joel Zivot, an associate professor of anaesthesiology and surgery and an expert witness writes: *"I am quite certain that assisted suicide is not painless or peaceful or dignified. In fact, in the majority of cases, it is a very painful death."* [26]
- One of the aims of the Bill seems to be to reduce unassisted suicide. The presentation of physician-assisted suicide (PAS) as a means of suicide prevention is paradoxical and is not supported by the evidence. It is paradoxical because it presents a Bill that will facilitate assisted suicide as a means of preventing suicide. It may be that some would choose PAS who might otherwise die by unassisted suicide, but as PAS involves the "normalisation" of a form of suicide, it makes both PAS and unassisted suicide more imaginable. The evidence from America is that *legalising PAS leads to a significant increase in those who chose to die* (by PAS or by unassisted suicide) and *does not reduce unassisted suicide*. Indeed, there is some evidence that rates of unassisted suicide also increase.[27] The aim of preventing suicide would be better achieved by ensuring sufficient support and care (including palliative care) for those with a terminal illness, so that no one feels that suicide is the solution.
- Another aim seems to be to reduce the incidence of people dying by assisted suicide/euthanasia in other jurisdictions. It seems likely that if the Bill were passed then most people would prefer PAS in Scotland to AS in Switzerland, but the overall number of people who die by PAS/AS would likely increase, and thus more people would end their lives prematurely. The argument that Dignitas is "overburdened" and that Scottish law and medical ethics ought to change to help alleviate this is simply manipulative. Dignitas might be overburdened because it provides AS to individuals who do not have serious health issues. One elderly woman who Dignitas

[22] Oregon Death with Dignity Act 2018 Data Summary

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

[24] http://www.nejm.org/doi/pdf/10.1056/NEJMoa1000678

[25] https://bjgplife.com/2021/09/28/the-impact-on-general-practice-of-prescribing-assisted-dying-drugs/

[26] https://www.spectator.co.uk/article/last-rights-assisted-suicide-is-neither-painless-nor-dignified

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

helped to end her life said she was lonely and disliked her appearance in old age.[28] The question of Scotland outsourcing its problem is a commonly used argument in any debate about a controversial practice, and it should not have any bearing on decisions taken in a separate country with its own traditions, values and concerns.

- Mr. McArthur claims that his "proposal complements excellent palliative care" and "co-exists with support for more and better palliative care". This is hard to reconcile with the fact that the majority of physicians involved in palliative care oppose assisted dying. A poll carried out by the British Medical Association in 2020[29] found that 76% of palliative care physicians opposed a change in the law. In a 2019 survey conducted by the Royal College of Physicians, only 9% of palliative care physicians supported assisted suicide legalisation.[30] In addition, **if assisted suicide was legalised, most physicians who care for terminally ill patients would not be willing to participate in the practice.** Based on the survey conducted by the RCP, only 24% of doctors are willing to prescribe lethal medication. Only 18% of doctors in geriatric medicine, 24% in medical oncology, and 5% in palliative care stated that they were willing to participate.[31] The aim of having excellent palliative care in Scotland would be better achieved by listening to what those who specialise in such care actually want.
- The criticisms of Scotland's current legal framework are ill-founded. Mr. McArthur has failed to demonstrate that a change in legislation is necessary. The current law is neither unclear,[32] ineffectual nor excessively rigid. The real objection appears to be the law's chilling effect on those doctors who might wish to be involved in assisted suicide. Without a guaranteed legal defence for doctors who provide lethal substances to their patients, it is extremely unlikely that routine access to assisted suicide could be introduced to Scotland.

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

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

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

Select fully opposed. Points you could include in your comments:

- Reiterate that assisted suicide is wrong and that **no process can fully protect the vulnerable from coercion.**
- The process relies on doctors certifying patients for assisted suicide, prescribing the medication, and being present when it is administered. **Most physicians do not support a change in the law to legalise physician-assisted death, especially those with experience caring for terminally ill patients.** Based on the 2019 survey conducted by the Royal College of Physicians, only 32% of doctors support the legalisation of physician-assisted death, with 43.4% of respondents opposing a change in the law.[33]

[28] Ole Hartling, *Euthanasia and the Ethics of a Doctor's Decisions: An Argument Against Dying*. Trans. Tim Davis(Bloomsbury 2021), 137-138.
[29] https://www.bma.org.uk/media/3367/bma-physician-assisted-dying-survey-report-oct-2020.pdf
[30] Royal College of Physicians, Assisted Dying Survey 2019 results, accessed from https://www.rcplondon.ac.uk/news/no-majority-view-assisted-dying-moves-rcp-position-neutral
[31] Ibid.
[32] In a 2016 ruling, the Inner House categorically rejected the claim that Scotland's Prosecution Code was "not sufficiently precise and accessible so as to enable a party to foresee the consequences of his actions and to allow him to regulate his conduct accordingly". See Reclaiming Motion by Gordon Ross Against the Lord Advocate, Second Division, Inner House, Court of Session [2016] CSIH 12 P1036/14
[33] https://www.rcplondon.ac.uk/news/no-majority-view-assisted-dying-moves-rcp-position-neutral

- More significantly, **if assisted suicide was legalised, most physicians who care for terminally ill patients would not be willing to participate in the practice.** Based on the survey conducted by the RCP, only 24% of doctors are willing to prescribe lethal medication. Only 18% of doctors in geriatric medicine, 24% in medical oncology, and 5% in palliative care stated that they were willing to participate.[34] Such a situation would lead to patients "shopping" for one of the few doctors who were willing to participate, and who inevitably would not be familiar with the patient. In the first decade of legalisation (1997-2007) in Oregon, one quarter (62/271) of all lethal prescriptions in Oregon were provided by just three doctors.[35] The 2020 Oregon Death with Dignity report notes that some assisted suicides were approved by doctors who had known the patients in question for less than a week. Only three out of the 245 who died were referred for psychological or psychiatric evaluation.
- **Requiring the presence of the doctor or healthcare professional could provide subtle emotional pressure on the patient to take the lethal medication.** In Switzerland, guidelines indicate that the prescribing doctor should not be present when the patient takes the lethal medication, to avoid any form of emotional manipulation. The presence of a medical professional cannot, therefore, be straightforwardly presented as a safeguard.
- **Many doctors oppose assisted suicide being part of mainstream healthcare, even if it is legalised.**[36] It is not explained why it is doctors who should take on the role of ending life. Since the time of Hippocrates in the fifth century BC (and no doubt before then) medical ethics has sought to ensure that doctors dedicate their skills completely to life and to healing, not to killing and suicide. The 1949 International Code of Medical Ethics states: "A DOCTOR MUST ALWAYS bear in mind the Obligation of preserving human life."[37] Medicine should be the last profession to be actively involved in helping people to kill themselves.
- **Assisted suicide should not be considered a medical procedure.** Assisted suicide undermines the traditional goal of medicine; namely, to cure and care, but not to harm or kill patients. Medical professionals have been trained exclusively to preserve and protect life, including receiving training and developing expertise in suicide prevention. 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.[38]

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

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

Please explain the reasons for your response

Select "fully opposed". Points you could make in your comments:

- **No safeguards are good enough.** Are we prepared to risk even one vulnerable person dying who didn't want to, so that others can be killed at their own request? Any mistakes in approving and allowing an assisted death can never be undone – death is final.

[34] Royal College of Physicians, Assisted Dying Survey 2019 results.
[35] Concentration of Oregon's Assisted Suicide Prescriptions & Deaths from a Small Number of Prescribing Physicians by Kenneth R. Stevens, Jr. MD. Revised 3/18/2015
[36] https://kadoh.uk/
[37] International Code of Medical Ethics adopted by the Third General Assembly of The World Medical Association, London, England, October 1949.
[38] See: Exit – Le Droit De Mourir, https://www.youtube.com/watch?v=7iNYTj_G03k

- The risk to the vulnerable of assisted suicide includes the risk of subtle pressure, coercion, and self-pressure – all things **next to impossible to safeguard against.** The Reclaiming Our Futures Alliance (ROFA) is a national alliance of disabled people's groups and individuals. In 2015, at the time of the Marris Bill, which sought to legalise assisted suicide, ROFA put out this statement:

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

- **The very fact of informing a patient that assisted suicide is an option could create pressure on a vulnerable patient.** The language commonly used to the effect that assisted suicide is "dying with dignity" suggests to people that their illness and suffering are *undignified*. To vulnerable people at the most difficult stage of their life, that language itself creates pressure. Who wants to be undignified?
- A process that is intended to end the life of a person can **never be considered safe.**

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

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

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

Select fully opposed. Some points you could make:

- Creating a body responsible for reporting and collecting data **cannot address possible abuse.** For example, in Oregon, doctors who supply lethal drugs to patients are required to declare this to the Oregon Health Authority (OHA) by ticking a series of boxes. But there is no case review system to examine how requests for lethal drugs have been handled. As the OHA makes clear on its website, it does not investigate whether people who have been supplied with lethal drugs met the conditions laid down in the law. With such a closed system, it is impossible to say that there has been no abuse of the law.[39] Since legalised assisted suicide is shielded by doctor-patient confidentiality, "in effect, any physician-assisted suicide regulation must, in the end, be physician self-regulated".[40]

[39] Truths & Half Truths About Assisted Dying, Living and Dying Well, https://www.dyingwell.co.uk/wp-content/uploads/2021/05/Truths-and-Half-Truths-about-Assisted-Dying-A5-Final.pdf
[40] Daniel Callahan and Margot White (1966)"The Legalisation of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village",30 Uni Richmond Law Rev 1.

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

- Legislation relating to conscientious objections is the responsibility of the UK Parliament in London. **Mr. McArthur can therefore make no promises about what a conscience clause would look like.**
- Doctors who have a developed conscience and believe that all life is valuable should not be pressured to facilitate suicide in some way or face penalties while those that are willing to take part in helping their patients kill themselves are rewarded.
- The document states that doctors would be required to refer patients to another doctor for assisted suicide. As well as creating a dangerous culture of "doctor shopping", this does not allow doctors to conscientiously object in a meaningful sense. It is likely that it would eventually become mandatory for all doctors to inform their terminally ill patients that assisted suicide was an option and refer them to other doctors for this to be carried out. Doctors who are clearest about their duties to their suicidal patients will refuse to do this. Will it be possible for doctors who believe strongly that assisting suicide is wrong to continue to work within the NHS, once this becomes common practice in NHS hospitals? Or will the NHS lose caring and qualified professionals that we cannot afford to lose?

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.

Select "some reduction in costs". Some points you could include:

- It is extremely concerning that the consultation indicates that the possible consideration of healthcare costs may be a factor in the legalization of assisted suicide. The consultation says:

"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."[41]

[41] Liam McArthur MSP, Assisted Dying for Terminally Ill Adults (Scotland) Bill Consultation, footnote 123; the following reference is also provided: Trachtenberg A. J., Manns, B. "Cost analysis of medical assistance in dying in Canada." CMAJ. 2017;189(3):E101-E105. DOI:10.1503/cmaj.160650.

- Other advocates of assisted suicide have argued that legalising assisted suicide would save the NHS money. The late Baroness Warnock, who exercised great influence over medical ethics, spoke of a chillingly "duty to die", saying: "If you're demented, you're wasting people's lives – your family's lives –and you're wasting the resources of the National Health Services."[42]

More recently, researchers have calculated the amount of "wasted resources" spent on caring for terminal cancer patients.[43] The authors are quick to add that "in no way is it intended to suggest that any such care should be denied to any patient".[44] But that is precisely what the patient in such a condition will perceive is being implied by the argument that if they would choose death instead of ongoing care they will save money for "more worthy" causes.

The system for assessing cost-effectiveness in the NHS –Quality Adjusted Life Years (QALYs) – is already used in treatment decisions for patients considered to have poor quality of life. Under this formula, someone's life is sometimes judged worse than being dead.[45] Mr. McArthur can offer no guarantees that pressure on NHS budgets will not gradually lead to administrative policies that would view the promotion of assisted suicide as the preferred, possibly the only, treatment option for patients seen as a drain on NHS resources.

- It is especially worrying that the question of costs is being raised at a time when people have been urged to "save the NHS" during the Covid crisis. No suggestion should ever be made that hastening one's death would reduce costs for the NHS.

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.

Select "Negative". Points you could make:

- **Age.** Older people are vulnerable to pressure to choose assisted suicide (see points on age in Question 1), both because of the prevalence of elder abuse and because many already feel that they are a burden. Legalising assisted suicide will lead to some vulnerable people contemplating 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 that:

  "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."[46]

- **Disability.** Many of the points about vulnerable elderly people also apply to those made vulnerable through disability. Many disabled people fear assisted suicide. It is opposed by UK organisations working closely with and on behalf of disabled people including:
  - Scope
  - Action on Elder Abuse
  - Mencap
  - Veterans Association UK[47]

Many of the reasons people choose assisted suicide in other jurisdictions are disability issues (see points on disability in Question 1). Legalising assisted suicide means that some people who say they want to die will receive suicide intervention, while others will receive suicide assistance. The difference between these two groups of people will be their health or disability status, leading to a two-tiered system that results in death for the socially devalued group.[48]

- **Race.** Assisted suicide is particularly dangerous for marginalised groups. Assisted suicide proponents have been characterised as the ''white, well-off, worried, and well'', who fail to understand the disproportionate impact of an option of assisted suicide upon people who are socially marginalised and whose limited options for genuine care and support seriously limit their autonomous choices.[49]

- **Religion or belief.** Although many healthcare practitioners oppose assisted suicide, because of the danger to the vulnerable or because it is not good medicine, the Bill will impact medics who reject assisted suicide because of their religion or belief.

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

[43] Shaw D & Morton A (2020) Counting the Cost of Denying Assisted Dying. *Clinical Ethics* (In Press).

[44] Ibid.

[45] Alan Williams. (1985) "The Value of QALYs",94 Health and Social Care Journal, 3.

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

[47] http://www.carenotkilling.org.uk/letters/charity-chiefs-denounce-bill/

[48] Coleman D. (2002) "Not Dead Yet: The Case against Assisted Suicide. For the Right to End-of-Life Care". Eds. Foley K. & Hendin H., John Hopkins University Press. Baltimore, 221.

[49] Pike, Euthanasia and Assisted Suicide, 2020.

Sustainability

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

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

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

- Yes
- No
- Unsure

Please explain the reasons for your response

Select "no". Points you could include:

- A just society does not make provision to kill its oldest and most vulnerable members.
- "Achieving a sustainable economy" in relation to assisted suicide implies that dying or ill people should take the cost of their treatment into consideration. This is coercive and has no place in a civilised society.
- Considering environmental limits is also coercive, in an atmosphere where many people argue that the population needs to be reduced for environmental reasons.
- The scientific evidence shows that assisted suicide laws are always subject to expansion.

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)?

We suggest that you add any points that you have not managed to fit into the other answers, either from your own experience or from our suggestions.

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