Is there evidence that chronically ill and disabled lives will be seen as disposable and devalued?

https://www.mydeath-mydecision.org.uk/2024/05/13/the-views-of-disabled-people-within-the-assisted-dying-debate/

https://www.theguardian.com/society/2025/jun/02/disabled-woman-killed-herself-after-dwp-mistakenly-withdrew-benefits

A Canadian case, cited by AD opponents is that of Rose Finlay[1] [2] in Ontario, who publicly claimed that delays in receiving disability support were longer than if she chose to access MAiD (AD). While the inference, much reported by AD opponents was that she could be driven to apply for MAiD by the lack of disability support, it was a rhetorical device and Rose Finlay is still very much alive. Supporters of AD argue that the answer to a problematic benefits and support system was never to withdraw and deny AD support to those who are disabled or chronically ill - the answer is to ensure the overall support system is fit for purpose.

Citing 'Nothing About Us Without Us'[3], the Church of Scotland Joint Report of the Theological Forum and the Faith Action Programme Leadership Team on Assisted Dying note that:

> "In Canada when MAiD (Medical Assistance in Dying) initially excluded those with disabilities to protect the vulnerable of society, it was disabled people who sued and won the right to be included in MAiD."

Respecting and enabling personal agency of those who are chronically ill and/or disabled can be achieved within a robustly regulated system of safeguards. Denying personal agency is increasingly viewed as an act of significant devaluation. As Christopher Riddle notes:

---

[1] Cheese, Tyler (2023) *Quadriplegic Ontario woman considers medically assisted dying because of long ODSP wait times*. CBC News. https://www.cbc.ca/news/canada/toronto/rose-finlay-medically-assisted-dying-odsp-1.6868917

[2] Graziosi, Craig (2023) *Disabled Woman Claims Canada is Forcing Her to Die by Assisted Suicide: "It's Not What I Want"*. Independent. https://www.independent.co.uk/news/world/americas/diabled-woman-canada-assisted-suicide-b2363156.html

[3] Book, Brett Ryan. Nothing About Us Without Us. Canadian Bar Association. August 24, 2022 https://www.cba.org/Sections/Health-Law/Resources/Resources/2022/HealthEssayWinner2022

> "Denying people with disabilities the right to exercise autonomy over their own life and death says powerfully damaging things about the disabled, their abilities, and their need to be protected."[4]

As part of the campaign of opposition to assisted dying, opponents' claims have been used to amplify concerns of some disabled and chronically ill individuals and groups. In addition, the past decade has seen reports of a Westminster government that has encouraged PIP bullying (with attendant deaths), the bedroom tax, the Dash Report[5] into the problems with the Care Quality Commission, and the attendant scandals in care, and on 15th September lat year the new Westminster government announced that 1.6m disabled OAPs were set to lose winter fuel payments.[6] In March 2025 Labour in Westminster announced potential severe cuts to disability support in England, with a likely knock-on effect on funding in Scotland, which may further amplify those concerns. It is with good reason that some in the disabled community would remain suspicious of government-led propositions. However, the Social Care (Self-directed Support) Act 2013 was put in place in Scotland to ensure that care and support is delivered in a way that supports choice and autonomy in each disabled person's life, and the recommendations of the Feeley review[7] of adult social care for the Scottish government, which involved direct consultation with the Scottish disabled community, indicates a positive direction of travel in terms of protections and support for Scottish disabled people.

6.1 Opposition and support for AD in the disabled community

Despite a justified cynicism towards government, support for assisted dying remains high within the disabled community. A majority of disabled and chronically ill people support assisted dying.

---

[4] Riddle, C.A. (2017) Assisted Dying & Disability. Bioethics 31: 484-9. Cited in https://policyscotland.gla.ac.uk/wp-content/uploads/2021/09/PolicyBriefingDisabilityAndAssistedDyingLaws.pdf

[5] Department of Health & Social Care (2024) *Independent report: Review into the operational effectiveness of the Care Quality Commission: interim report.* https://www.gov.uk/government/publications/review-into-the-operational-effectiveness-of-the-care-quality-commission/review-into-the-operational-effectiveness-of-the-care-quality-commission-interim-report

[6] Helm, Toby (2024) *Charities demand to meet UK ministers as 1.6m disabled OAPs set to lose winter fuel payments* https://www.theguardian.com/society/2024/sep/15/charities-demand-to-meet-uk-ministers-as-16m-disabled-oaps-set-to-lose-winter-fuel-payments?fbclid=IwY2xjawFTbO1leHRuA2FlbQIxMQABHRVJRNHE2xXo6ke97b-ID85E62UXHMijsiNfCIdvAjFm4mu-yzWoE6M30A_aem_q0wZ3VTNyF17cvPtG-HU-A

[7] https://www.gov.scot/publications/independent-review-adult-social-care-scotland/pages/2/

According to a 2013 Yougov poll[8] for Dignity in Dying only 8% of disabled people surveyed believed that disability rights groups should maintain their opposition to assisted dying, while of the 1,036 disabled people asked, 79% supported a change in the law.

A 2021 survey of 140 disability rights organisations in the UK indicated that only 4% explicitly oppose assisted dying laws. A substantial majority either remain silent (84%) or explicitly endorse neutrality (4%) on assisted dying[9].

While a number of disability activists took a stance opposing assisted dying in 2007, "75% of disabled people taking part in the 2007 British Social Attitudes Survey believed that those with a terminal and painful illness should be allowed an assisted death."[10]

In a 2015 poll 88% of people who identify as disabled supported a change in the law in at least some circumstances.

The 2021 University of Glasgow study "Disability and Assisted Dying Laws Policy Briefing"[11] concluded that people with disabilities are not generally opposed to assisted dying laws. The study also confirmed that assisted-dying laws do not harm or show disrespect for people with disabilities, nor does the introduction of such legislation damage healthcare for people with chronic illness and/or disabilities.

A 2023 YouGov poll[12] in Scotland found that 79% of disabled people support legalising assisted dying.

---

[8] https://www.dignityindying.org.uk/news/just-8-disabled-people-surveyed-believe-disability-rights-groups-maintain-opposition-assisted-dying/#:~:text=The survey found that of 1,036 disabled,assistance to die to non-terminally ill people. 29/04/25

[9] Box, G. & Chambaere, K. (2021) Views of disability rights organisations on assisted dying legislation in England, Wales and Scotland: an analysis of position statements. Journal of Medical Ethics. Published online first 5 January 2021. doi: 10.1136/medethics-2020-107021. Cited in https://policyscotland.gla.ac.uk/wp-content/uploads/2021/09/PolicyBriefingDisabilityAndAssistedDyingLaws.pdf

[10] Slouch, Roddy (2016) *Assisted dying: the search for a good death*. Critical and Radical Social Work vol 4, no 1: 93–102 https://www.academia.edu/78819091/Assisted_dying_the_search_for_a_good_death

[11] University of Glasgow (2021) *Disability and Assisted Dying Laws Policy Briefing.* https://policyscotland.gla.ac.uk/wp-content/uploads/2021/09/PolicyBriefingDisabilityAndAssistedDyingLaws.pdf

[12] https://www.theguardian.com/uk-news/2023/sep/17/majority-of-scottish-voters-support-assisted-dying-bill-poll-reports

6.2 Equality

An argument has been made that on the issue of equality, as well as personal autonomy, severely disabled individuals who would seek to end their lives due to unbearable and intractable suffering are disadvantaged by the law as it currently stands, as those who would require a lethal dose to be administered to them would not be supported in their wish. The inability of any individual to self-administer denies them the right to access assisted dying under the current provisions of the McArthur Bill, which is an issue of inequality. This remains a common argument for allowing any dosage to be administered when required.

Is there evidence that vulnerable people have been coerced into ending their lives or experience other pressures to do so?

Opponents of AD argue that even if AD is to the benefit of some, it may put others at risk, and equally that popular support for AD does not change the harms they claim exist and that any move to introduce AD may be, as Charles Mackay described, 'the madness of crowds', and as Tocqueville warned a 'majority tyranny' can still lead to harm for vulnerable groups and individuals. While to date, based on a wealth of international research there appears to be a dearth of independently peer-reviewed evidence from reliable sources to support the proposition, the proposition that the introduction of AD will lead to 'unwilling' deaths in the future is nonetheless worth exploring.

DNR/DNACPR/DNAR[13] notes being placed by doctors in the files of patients for whom they judge to be beyond effective treatment are common and already legal practice in the UK. This should be discussed with the patient and/or family, but such decisions can be made by the senior doctor responsible for the patient's care, after consulting with other relevant professionals, even if against the wishes of patients or their families.

In advance, individuals can complete Advance Decision to Refuse Treatment (ADRT) form or a living will - an advance directive detailing their preferences if in the future for medical reasons they are unable to be consulted. A Power of Attorney or Welfare Power of Attorney can be registered with the Office of the Public Guardian in Scotland to confer the right to ensure the individual's preferences and best interests are a communicated by a nominated individual. There is a lack of evidence to suggest coercion has played a part in this process in Scotland.

We do not have to look abroad to other jurisdictions to prove a lack of cases of coercion. For some time it has been legal for Scottish individuals to starve and dehydrate themselves to death (VSED/VRFF), often in concert with accepting an induced coma. Again, there is no proof of coercion in relation to the established practice of VSED in Scotland, or indeed elsewhere.

Establishing exactly when VSED was adopted as accepted practice within Scottish palliative care has been problematic. A key problem is that in

[13] In the event of heart failure, CPR would not be applied

general “such deaths are not even usually recorded as suicides”.[14] [15] The procedure itself has never been illegal in Scotland. If we can assume that VSED has been recognised for at least as long as it’s legitimacy was confirmed as supportable by medical staff by the ruling in relation to permissibility of withdrawing constant artificial nutrition and hydration in Scotland by the Scottish Court of Session in 1996[16], and reconfirmed by the Ross ruling by the Scottish Court of Session in 2016[17], we can posit that since these rulings, and likely before, VSED has been supported within palliative care in Scotland. If coercion was a significant problem in relation to VSED, the issue would most likely have come to light during this time.

Medical practitioners themselves experience ambiguity in terms of difference between VSED and AD[18]. In the end, it can be argued there is little difference between this legal version of dying by medically-supported starvation & dehydration/deterioration of organ function and AD, as proposed in the current Scottish legislative proposals, other than a matter of the extended period for the death to occur in the former. As for VSED as available and used in Scotland for years, there is no evidence to support AD opponents’ warnings of coercion by avaricious relatives. No cases can be cited where a person in Scotland has been coerced into adopting VSED, either by family or medical staff.

My Death, My Decision[19], state that:

> “There are other situations in healthcare, notably the refusal of life-saving treatment, where coercion is just as hypothetically possible, and the consequences equally profound, yet we allow these decisions, to

---

[14] Nancy Preston, Sheila Payne, and Suzanne Ost. Breaching the stalemate on assisted dying: it’s time to move beyond a medicalised approach
BMJ 2023; 382 doi: https://doi.org/10.1136/bmj.p1968 (Published 29 August 2023)
Cite this as: BMJ 2023;382:p1968
27/04/25

[15] Uemura T, et al. Challenges in Completing a Death Certificate After Voluntary Stopping of Eating and Drinking [published online: July 27, 2023]. J Am Med Dir Assoc. DOI: https://doi.org/10.1016/j.jamda.2023.06.022.

[16] *Law Hospital NHS Trust v Lord Advocate* 1996 SC 301: p306. https://www.bailii.org/scot/cases/ScotCS/1996/1996_SC_301.html

[17] *Ross v Lord Advocate (*2015). https://www.casemine.com/judgement/uk/5a8ff7ec60d03e7f57eb2e21

[18] Gerson et al. (2019) 18:75 BMC Palliative Care. https://doi.org/10.1186/s12904-019-0451-4

[19] A campaign group in favour of legalising AD for adults of sound mind who are either terminally ill or suffering intolerably from a physical, incurable condition.

> respect patient autonomy. An assisted dying law would provide a regulated process."[20]

It would be remiss however to ignore the extensive international research and proof relating to AD that coercion simply is not the issue claimed by opponents. Professor Battin et al, concluded in a comprehensive study on this topic:

> "Where assisted dying is already legal, there is no current evidence for the claim that legalised [assisted dying] will have a disproportionate impact on patients in vulnerable groups."[21]

Sir Graeme Catto noted:

> "In Oregon the law was changed 16 years ago [now 27 years ago] to allow terminally ill, mentally competent adults the choice of an assisted death. There has been no evidence of coercion; those who opted for an assisted death, while often physically frail, were feisty, articulate individuals who had made their views well known, often against the wishes of their family."[22]

As Dr Alison Payne (A British GP practicing in New Zealand) stated:

> "I have not yet seen evidence of coercion–more often the family are reluctant for it to happen."[23]

Unreliable anecdotal statements by opponents of assisted dying are outweighed by systematic evidence grounded in data collection and regular reports in states which allow AD.

---

[20] House of Commons, Health and Social Care Committee, Assisted Dying/Assisted Suicide. Second Report of Session 2023–24: Report, together with formal minutes relating to the report: 62 https://committees.parliament.uk/publications/43582/documents/216484/default/

[21] Battin et al (2007) *Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups. J Med Ethics Oct;33(10):591-7.* https://www.ncbi.nlm.nih.gov/pubmed/17906058

[22] Catto, G & Finlay IG (2014) *Assisted death: a basic right or a threat to the principal purpose of medicine?* J R Coll Physicians Edinb 2014; 44:135 https://www.rcpe.ac.uk/sites/default/files/current_controversy_0.pdf

[23] House of Commons, Health and Social Care Committee, Assisted Dying/Assisted Suicide. Second Report of Session 2023–24: Report, together with formal minutes relating to the report: 32 https://committees.parliament.uk/publications/43582/documents/216484/default/

Opponents of assisted dying claim that families pressurising the vulnerable to end their lives, either for convenience or for personal gain is a very real and likely danger if assisted dying legislation is enacted in Scotland. They provide no reliable evidence from countries that already offer assisted dying. The inference is therefore that if there is no evidence elsewhere, then Scottish people, or British people in general, are somehow unique as a nation of 'Burke & Hare grave-robbers' pressurising the vulnerable to kill themselves. As the Conservative MP Kit Malthouse noted "the British people do not understand this view that the country is teeming with granny killers".[24]

Supporters of the terminal proviso in the McArthur Bill, and therefore a predictable and imminent death, argue that it removes much of any possible risk of coercion.

Assisted dying has been available for some time in states across the world. Yet there remains no dossiers of cases and prosecutions of those who have pressurised vulnerable people to end their lives. We do however see significant anecdotal evidence of the opposite. Families often oppose the choice of their loved one to seek assistance in dying. Many only come around to the idea as they see how terribly their loved one is suffering. Nonetheless, the Scottish bill creates a separate offence, punishable by up to fourteen years in prison and/or a fine, in addition to stringent multi-stage checks.

5.1 Burden

Concern about the level of physical suffering that may be experienced may be paramount, but other concerns exist.

Knights et al[25] interviewed families of "UK-based individuals considering an assisted death and family members of those who have completed an assisted death." In terms of priorities in considering an assisted death, at the forefront of other priorities were the ""burden" of illness" and "the value of autonomy and control over death". In the former, the understanding of "burden' was significantly broader than simply concerns about the pressures on family to provide caring. In fact, in citing concerns about the 'burden' that concerned those considering AD, Knights et al noted that:

---

[24] Malthouse, Kit Assisted Dying Volume 749: debated on Monday 29 April 2024. https://hansard.parliament.uk/commons/2024-04-29/debates/B3A72309-26A0-4F8F-9B48-308B063B82E5/AssistedDying

[25] Knights et al (2024) *Accessing an assisted death from the UK: Navigating the legal 'grey' area.* Death Studies, 1–10. https://doi.org/10.1080/07481187.2024.2414264

> "living with their severe and/or degenerative illness was experienced as a disintegration of self, no longer being able to enjoy things they used to do, combined with an anticipated fear about the illness course and possible impacts on those around them."

The potential 'impacts' included the trauma that loved ones would experience in witnessing the prolonged suffering and loss of dignity of somebody they loved.

Supporters of AD argue that the availability of that choice offers a sense of peace and comfort, and an ability to enjoy and embrace the time left. Bolt et al[26] cite a number of studies confirming that "having control over the dying process is identified as a key attribute of a good death in Western society".

5.2 Structural vulnerability

Opponents of AD argue that the sufferers are confused, driven to suicidal ideation in some cases by their living conditions. As Roddy Slorach argues:

> "Personal choice is not equally available or equally exercised across society and it can carry little real meaning for the majority of people whose lives are dominated by a constant struggle to make ends meet."[27]

In terms of structural vulnerability, such vulnerability can be assessed on a case-by-case basis. As Justice Baudoin noted in the Truchon case in Canada, a whole community cannot be denied access to assisted dying simply because they are perceived to be disadvantaged socially. Downar et al concluded that there are:

> "powerful drivers of mortality among the structurally vulnerable, and that AD is not one of them. This makes it hard to argue that legalizing AD puts the lives of the vulnerable at risk or, conversely, that criminalization of AD offers protection…..Some opponents of AD are quick to point out that there may be exceptions and outliers—cases wherein we cannot exclude the possibility that poverty or other forms of structural vulnerability contributed to the decision to request AD. Unfortunately, many of these cases have proven to be misrepresented.

---

[26] Bolt EE, Hagens M, Willems D, Onwuteaka-Philipsen BD. Primary care patients hastening death by voluntarily stopping eating and drinking. Ann Fam Med. 2015 Sep;13(5):421-8. doi: 10.1370/afm.1814. PMID: 26371262; PMCID: PMC4569449.

[27] https://www.academia.edu/78819091/Assisted_dying_the_search_for_a_good_death?email_work_card=view-paper

> In Canada, media widely reported the case of a woman with multiple chemical sensitivities who received AD, along with claims that she was driven to AD through poverty and lack of adequate housing rather than intolerable suffering related to her underlying condition. The patient herself refuted these claims in a note written before her death. Another person with a chronic debilitating condition was reported to be requesting AD purely due to impending homelessness. The patient himself contradicted this assessment, and wrote that his story was "hijacked by the right trying to spin it into their own agenda."[28]

In another study, Downar et al state:[29]

> "we found that people who chose MAiD reported physical or psychologic suffering as the primary reason, despite engagement of palliative care in about three-quarters of patients, which suggests that for many patients the MAiD requests were not because of poor access to palliative care. Recipients of MAiD were younger, had higher income levels, were substantially less likely to reside in an institution and were more likely to be married than decedents from the general population, suggesting that MAiD requests are unlikely to be driven by social or economic vulnerability….Another common concern about the legalization of MAiD is the potential for people who face social or economic vulnerabilities to be pressured into MAiD. However, our data indicate that people from traditionally vulnerable demographic groups (from an economic, linguistic, geographic or residential perspective) were far less likely to receive MAiD, consistent with findings from the US and Europe"

5.3 Would medical staff coerce a patient to agree to an assisted death?

Critics of AD also argue that doctors will be incentivised to push patients towards AD either for personal financial gain or to save money for medical insurance companies or health boards.

---

[28] Downar et al (2023) *Medical Assistance in Dying, Palliative Care, Safety, and Structural Vulnerability*. J Palliat Med. 2023 Sep;26(9):1175-1179. doi: 10.1089/jpm.2023.0210. Epub 2023 Jul 3. https://pubmed.ncbi.nlm.nih.gov/37404196/

[29] Downar J, Fowler RA, Halko R, Huyer LD, Hill AD, Gibson JL. Early experience with medical assistance in dying in Ontario, Canada: a cohort study. CMAJ. 2020 Feb 24;192(8):E173-E181. doi: 10.1503/cmaj.200016. Epub 2020 Feb 11. PMID: 32051130; PMCID: PMC7043822. https://pmc.ncbi.nlm.nih.gov/articles/PMC7043822/

Barbara Wagner in Oregon[30] was cited by opponents as an example of how AD would be used as a rationale for cutting costs and refusing expensive treatment. Wagner was refused support for specific drugs for terminal cancer treatment by her insurer. She claimed that she was advised to consider an assisted death, as the treatment for her cancer was not available to her on her medical insurance policy. It is likely she would have been refused, whether or not the AD was available in her state. As an admitted opponent of AD, she was comfortable to allow opponents of AD try to draw a direct causal link to AD, rather than the criteria used by the insurance company to reject the treatment in question. However, health-providers everywhere consistently refuse patients access to specific treatments as a matter of course, on the basis of efficacy or cost[31]. In the US medical insurance operates on differently priced tiers, and as a low wage earner (articles confirmed a series of low-paid jobs), it is also not unreasonable to assume that Ms Wagner also held a policy with poorer coverage that excluded the treatment she requested. It is unlikely Ms Wagner would have been offered her preferred treatment regardless of whether AD was available in the state. In the UK, all treatment in the NHS is free and equal at the point of delivery. As Loewy notes, the United States:

> "lack universal access to basic medical care with close to 20% going un-insured while a vast number of people are so badly underinsured or burdened by co-payments that they often cannot see physicians until it is too late."[32]

Slorach[33] confirms that the Oregon Health Plan covers the cost of assisted suicide but excludes many important services and drugs. The issue is with overall health-care provision, not AD.

---

[30] ABC News (2008) Death Drugs Cause Uproar in Oregon. https://abcnews.go.com/Health/story?id=5517492&page=1

[31] For example in October 2024 the National Institute of Health and Care Excellence (Nice) rejected for widespread use by the NHS a new Alzheimer's drug Donanemab, and another, Lecanemab, was also rejected several months earlier, both on the basis of insufficient benefit for the cost.

[32] https://www.academia.edu/113873484/Euthanasia_Physician_Assisted_Suicide_and_Other_Methods_of_Helping_Along_Death?email_work_card=view-paper

[33] https://www.academia.edu/78819091/Assisted_dying_the_search_for_a_good_death?email_work_card=view-paper

Loewy[34] opines that

> "legalizing PAS and euthanasia is safe only where patients have universal access to health care."

Two truths can exist independently. If a sufferer chooses an assisted death over a long and drawn out agonising death it is their personal decision. As an unintended consequence less money may be spent on that patient and a bed will be freed up, and overall savings may result[35] [36]. The Westminster Impact Assessment for the Terminally Ill Adults (End of Life) Bill, published on May 2 2025 indicated minor savings overall within the context of the NHS budget for England and Wales.[37] This remains a consequence, not an objective. Decisions to withhold or withdraw treatment have been made within Scottish medicine for many years, as have decisions to deal with patient suffering by medicating at a level that is understood may be fatal - all such decisions can lead to death, but the intention is not to make savings in the reallocation of resources. Where suffering individuals choose to starve and dehydrate themselves to death (legal under current Scottish law), suffering is curtailed and it is likely less money is committed overall in comparison to resources required for a longer drawn out death. The patient's best interests remain the priority of the Scottish medical profession. Perhaps most significantly, the proposed Bill limits access to AD to those who will die imminently, which to a large degree removes any likelihood of coercion, unless the perpetrator was unwilling to wait the limited extra months it would take for a person to die.

5.4 Support already available to individuals and families struggling and under pressure

---

[34] https://www.academia.edu/113873484/Euthanasia_Physician_Assisted_Suicide_and_Other_Methods_of_Helping_Along_Death?email_work_card=view-paper

[35] Emanuel, Ezekiel J & Battin, Margaret P (1998) *What Are the Potential Cost Savings from Legalizing Physician-Assisted Suicide?* New England Journal of Medicine 1998;339:167-172. https://www.nejm.org/doi/full/10.1056/NEJM199807163390306#:~:text=To many, savings from reduced,are both necessary and desirable.&text=Many have linked the effort,-life health care costs."

[36] Trachtenberg , Aaron J. & Manns, Braden (2017) *Cost analysis of medical assistance in dying in Canada*. Canadian Medical Association Journal. https://www.cmaj.ca/content/189/3/e101

[37] Impact Assessment: Terminally Ill Adults (End of Life) Bill (as amended in the House of Commons Public Bill Committee) **IA No**: DHSCIA9682 https://publications.parliament.uk/pa/bills/cbill/59-01/0212/TIABImpactAssessment.pdf

Additional problems are indeed often experienced as a result of chronic incurable conditions, such as loss of ability to socially interact, loss of mobility and the resulting isolation, depression, low financial resources and lack of sufficient social support, loss of personal autonomy and loss of dignity. They are unfortunately often part-and-parcel contributors to what sufferers experience as a life that is felt over time to be no longer worth living.

Where a person may have care needs that they feel would be too great for their families, there are choices in Scotland. The default choice is medical support, along with support from social services for in-home care, or access to the many care homes and palliative care facilities where full-time professional care is provided.