A critical examination of the arguments posed in opposition to assisted dying (with reference to the Assisted Dying for Terminally Ill Adults (Scotland) Bill).

Contents

Assisted Dying: Glossary of terms.

For the purpose of this document the term Assisted Dying (AD) applies to any process where medical support is provided to an individual in ending their life. Variations exist, both semantically and in terms of the range of medical involvement indicated.

It may be helpful to examine various definitions[1] that tend to appear in the debate, and are used in cited sources in this document.

Assisted dying (AD) was introduced by Lord Joffe in his Assisted Dying for the Terminally Ill Bill in 2004, and is the term used by World Federation of Right to Die Societies, and is most common in the UK to describe any act or procedure to end life for a person who is suffering. Assisted dying includes the provision of medication to a person for self-administration as well as administration of medication by a health practitioner, in both cases causing death. It is the primary term that will be used in this document.

For the purpose of this document, the process (AD) will be understood to include a consistent fully-informed autonomous request made by a patient with clear mental capacity to be able to self-administer a lethal dose. With reference to Cosyns[2], the process will be

> "as solely done in the interest of the patient being killed and in no other. The "interest of the patient", furthermore, is defined by the patient and not by the physician, the state or anyone else (at least as long as the patient has decisional capacity—whether advance directives ought to give or reserve such power is another matter). As only contemplated in case of incurable and terminal illness that is beyond either cure or prolongation of a quality of life acceptable to the patient. In other words, it is a matter of optionality where the options are narrowed to only two: to live longer at the price of suffering longer or to suffer for a shorter time at the price of shortening life."

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[1] Adapted from: https://wfrtds.org/what-is-assisted-dying/

[2] Cosyns, Marc. Euthanasia, Physician Assisted Suicide and Other Methods of Helping Along Death https://www.academia.edu/113873484/Euthanasia_Physician_Assisted_Suicide_and_Other_Methods_of_Helping_Along_Death?email_work_card=view-paper

Assisted Suicide: The term used to describe the distribution of a drug that can cause the death of a person. The term is used in Switzerland, Austria and the Netherlands.

Autonomy: the freedom and ability of a rational individual to express personal agency and make informed decisions without coercion.

Beneficence: acting in the best interest of the patient and to ensure an acceptable quality of life.

Deep sedation: a state of depressed consciousness where the patient is less able to maintain coherence or consciousness, but can respond.

Double effect: sometimes referred to as the rule or doctrine of double-effect (RDE/DDE) where a heavy dose is prescribed in the clear knowledge that it can shorten or end life. Many would argue that this has at least one foot in the euthanasia camp. Some argue that it has been used as cover for intended euthanasia, in cases of intractable suffering where the outcome has more clearly been foreseeable and predictable.

Euthanasia: Deliberate termination of life by someone else, on the explicit request of the person involved to ease incurable, intractable and unbearable suffering. In the past, the terms passive/active were added to make a distinction between ending life-saving treatment (passive) and termination of life on request (active). The term is used in the Netherlands, Belgium and Luxembourg.

The original meaning of euthanasia was ‘a good death’. (Active) euthanasia is where the physician administers the medication, perhaps because the patient cannot self-administer or swallow e.g. due to paralysis or oesophogeal cancer.

Justice: in this context, fairness and equal treatment and access to social support and medical resources and benefits.

Legal assisted dying: In those jurisdictions where it is legal, assisted dying is an end of life choice for people who meet the eligibility criteria established by the law in their jurisdictions. Each jurisdiction requires the request to be voluntary.

Medical Aid in Dying (MAiD): The term used by some parties in the USA.

Medical Assistance in Dying (MAiD): The term used in Canada. In Canada MAID can be provided by either a physician or a nurse practitioner or it can be self-administered. In the case of self-administration, the physician or nurse practitioner provides or prescribes a drug that the eligible person takes themselves.

Non-maleficence: a duty to cause no intentional harm to a patient.

Passive euthanasia can be regarded as the refusal to provide or withdrawal of treatment.

Physician Assisted Suicide (PAS)/Physician Assisted Dying (PAD): where a physician provides, at the competent request of a patient, drugs which the patient can self-administer with the intention to end their life.

Terminal sedation: sometimes referred to as palliative or continuous sedation, a coma is induced and maintained until the patient dies. Recognised by Beauchamp and Childress[3] to challenge "the boundaries and use of the RDE [rule of double-effect]…Some commentators contend that some cases terminal sedation can be justified under the RDE, whereas others argue that terminal sedation directly, although slowly, kills the patient and thus is a form of euthanasia".

Terminally ill: According to Assisted Dying for Terminally Ill Adults (Scotland) Bill, "For the purposes of this Act, a person is terminally ill if they have an advanced and progressive disease, illness or condition from which they are unable to recover and that can reasonably be expected to cause their premature death." Based on legislation elsewhere, for the purposes of this document, death predicted within a six to twelve month period will qualify a condition as terminal.

Voluntary Assisted Dying (VAD): The term is used in Australia. VAD is the provision of medical assistance to a terminally ill person for self administration of a drug which will cause their death. If the person is no longer able to self administer, a doctor can administer the drug.

Voluntary Stopping of Eating and Drinking (VSED): Also known as Voluntary Refusal of Food and Fluids (VRFF), this is a process which often

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[3] Beauchamp, TL & Childress, JF. The Principles of Biomedical Ethics, 7th Ed. Oxford University Press (2013): p168

involves medical staff (although it can also be carried out independently) to 'hasten' their death. The process is not restricted to terminal patients. Commonly done in conjunction with deep/terminal sedation and continuous care provided by medical staff. According to Wax et al[4],

> "Voluntary stopping of eating and drinking (VSED) is a deliberate, self-initiated attempt to hasten death in the setting of suffering refractory to optimal palliative interventions or prolonged dying that a person finds intolerable. Individuals who consider VSED tend to be older, have a serious but not always imminently terminal illness, place a high value on independence, and have significant illness burden."

[4] John W. Wax MD, Amy W. An MD, Nicole Kosier MD, Timothy E. Quill MD. Voluntary Stopping Eating and Drinking. Journal of American Geriatrics Society, Volume66, Issue3 March 2018, Pages 441-445

1 Introduction

Dworkin[5] suggests that legalisation of Assisted Dying (AD) can occur via two routes.

The first is by iterative change (as witnessed in the Netherlands and Canada) primarily initiated via the precedent of case-law rulings. For a period of time AD remains illegal in name, but prosecutors are encouraged to show discretion, and compassion/mercy is accepted as the motive and taken into consideration in sentencing.

While all of the above are technically in play in Scotland, there remains a lack of court-ruling precedents, and where rulings have occurred, courts have been unwilling to make substantive changes to the law as it stands (regarding such change as a matter for the Scottish Parliament), although some guidance has been provided. However, our overloaded court-system will likely remain an unwilling forum to establish any change in the existing law.

In addition, we already have the legally-acceptable application of treatments that kill a patient but fall within the doctrine of double-effect and notions of compassionate intent. We already commonly practice heavy/terminal sedation - drug (over)dosage of patients. We have practiced for some time 'voluntarily stop eating and drinking' (VSED) where medical staff support the dehydration and starvation of patients. We already have court agreement[6] and accepted medical practice in the withdrawal of life maintaining treatment for those in a persistent vegetative state (PSV) and other contexts where further treatment is regarded as futile in preserving an acceptable quality of life. We already have court agreement that friends or family members can accompany a consenting individual to their chosen location for euthanasia[7].

However ambiguity remains that would appear to be unsustainable in view of an aging population increasingly subject to multiple incurable chronic conditions as they age. It is likely that an increasing number of Scots will face unbearable and intractable suffering, and the demand for legal clarity on AD will increase.

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[5] Dworkin, Gerald. Should Physician-Assisted SuicideBe Legalized? from Giving Death a Helping Hand: Physician-Assisted Suicide and Public Policy. An International Perspective. Edited by DIETER BIRNBACHER and EDGAR DAHL 2008 Springer Science+Business Media B.V.

[6] Pamela R Ferguson. Causing death or allowing to die? Developments in the law. Journal of Medical Ethics 1997; 23: 368-372

[7] GORDON ROSS (reclaimer) against LORD ADVOCATE (respondent), appeal as heard by Lord Justice Clerk Carloway, Lady Dorrian and Lord Drummond Young. https://www.biodiritto.org/ocmultibinary/download/3033/29374/9/b701678c234eece5a1bd6ac39d5423c1.pdf/file/ross.pdf

The second way to (a clearer and more specific) codification of Assisted Dying within Scots law that would define protections for both medical staff and loved ones who may wish to support sufferers in seeking AD is via Parliamentary legislation. Two previous attempts, in 2010 and 2015, have been made to introduce some form of Assisted Dying legislation in Scotland. Liam McArthur has now introduced the Assisted Dying for Terminally Ill Adults (Scotland) Bill to the Scottish Parliament on 27 March 2024.

1.1 Background

In 1935 the Voluntary Euthanasia Society in the UK was established "with the support of influential medical men, churchmen, legal experts, and politicians…A movement to legalise an "easy death" for persons suffering from incurable and painful disease". This first attempt to present a bill (at Westminster) failed, but the issue has continued to be presented in the years since.

Concern existed in relation to previous legislative attempts to introduce AD crossing "so many untested bridges as to constitute what is, in effect, a leap into the unknown."[8] This is no longer the case. Euthanasia in Switzerland has been legal since 1941 and certainly available and practiced since 1942[9]. Assisted dying has existed legally elsewhere in the world since 1997 when it was introduced in Oregon. Subsequently other states and countries have also introduced similar legislation with an estimated 400 million people now having access to legal assisted dying.[10] It cannot be argued that the implementation of AD is untested in multiple arenas, or that there does not exist a panoply of independent case-studies or governmental data.

The overwhelming majority of people who make use of the access provided by these laws have cancer. It should also be noted that many sufferers who choose to make themselves eligible for assisted dying choose not to go through with it, but are simply happy to have peace of mind that the choice is there for them if needed.

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[8] Laurie, G & Mason, JK. Assistance in Dying or Euthanasia? Comments on the End of Life Assistance (Scotland) Bill. EdinLR Vol 14 pp 493-497 DOI: 10.3366/E1364980910001757 https://www.pure.ed.ac.uk/ws/portalfiles/portal/11939907/MASON_K_Assistance_in_Dying_or_Euthanasia.pdf

[9] Radbruch et al (2016) *Euthanasia and physician-assisted suicide: A white paper from the European Association for Palliative Care. Palliative Medicine 101-192.* https://journals.sagepub.com/doi/epub/10.1177/0269216315616524

[10] Hurley et al (2021) *Assisted dying: a question of when, not if*. BMJ 2021;374:n2128 https://doi.org/10.1136/bmj.n2128

> "Between 0.3% to 4.6% of all deaths are reported as euthanasia or physician-assisted suicide in jurisdictions where they are legal. The frequency of these deaths increased after legalization. More than 70% of cases involved patients with cancer. Typical patients are older, white, and well-educated… Existing data do not indicate widespread abuse of these practices."[11]

A small minority in terminal phase experience "severe" pain, despite receiving hospice/palliative care[12]. However, whether suffering from a single condition or a range of co-morbities, the experience is a unitary one, made up of a number of symptoms, experiences and side-effects in addition to extreme pain that combine to cause overall suffering.

Sufferers may rate the significance of each maleffect in their suffering in a different order - perhaps rating pain, or loss of autonomy, or loss of dignity as the worse element leading to their choice for an assisted death. For some, physical pain is such a core element that they see it as so unavoidable and integral that they may see it as causal rather than a result. The experience however remains a collective one. A bad death often comes as a collection of symptoms and experiences.

With each passing year more and more people either directly or through a loved one experience the shortcomings of the current legal options available to the incurably and intractably suffering.

In September 2024, a YouGov survey took an in-depth look at attitudes in the UK towards assisted dying. It found that 73% of Britons believe that assisted dying should be legal in the UK, with only 13% opposed. 70% of those supporting assisted dying (55% of the total surveyed) say that "assisted dying should be legal for patients with incurable conditions that are painful and/or debilitating, but not terminal."[13]

In the July 2024 survey 'Rethinking the UK's approach to dying'[14], it was the stated preference of 83% of respondents to prioritise their quality of life over

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[11] Emanuel et al (2016) *Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe.* JAMA. 2016;316(1):79-90. doi:10.1001/jama.2016.8499 https://jamanetwork.com/journals/jama/article-abstract/2532018

[12] Australian Palliative Care Outcomes Collaboration (PCOC)/Australian Government Department of Health (2020) Patient Outcomes in Palliative Care in Australia: National Report for July to December 2020: 35-36. https://documents.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/doc/uow269015.pdf

[13] https://yougov.co.uk/politics/articles/50989-three-quarters-support-assisted-dying-law

[14] https://compassionindying.org.uk/resource/rethinking-uk-approach-dying/

living longer in the last years of their life. Of the 1,214 people in the sample whose last close friend or family member to die died of a short or long-term illness, 26% said that a friend or family member received medical treatment they would not have wanted towards the end of their life.[15]

Attempts to seek clarification through judicial review in courts in the UK have tended to do so on the basis that the right to an Assisted Death within the UK was compatible with the right to a private life, bodily autonomy and self-determination guaranteed by Article 8 of the European Convention on Human Rights. Courts have ruled that either current guidance is clear enough and/or it is not the place of the judiciary to further develop policy on the matter.

Rights to freedom from torture and unreasonable suffering, the right to privacy, the right to autonomy and self-determination, the right to dignity, the right to control our own destiny, and indeed the right for a person to end their life - have all played a part in the overall debate. Suicide is not illegal in Scotland and assisting another person's death, to some degree, is also not illegal.

The only debate, legally, that remains is whether the scope and degree of intimacy of involvement in assisting a death can be extended and legally defined by statute - specifically, can a doctor supply a lethal dosage for self-administration (and/or can a doctor legally administer a lethal dose), with the specific intention of the dose taking effect within a short time after administration. The former would be enabled by Liam McArthur's proposals, but not the latter. In the Scottish proposals, a doctor may prescribe a fatal dose, but cannot legally administer it. As Warlow's summary[16] confirms:

> "the patient must administer any life ending substance themselves. They must be an adult, resident in Scotland, registered with a GP in Scotland, and mentally competent, as confirmed by two independent doctors. Important lessons from the last attempts to pass a bill on assisted dying in Holyrood have been incorporated into the new bill. For example, it does not allow an assisted death for anyone who is not "terminal" (meaning close to death, but within no specific time period) even if they have a debilitating, incurable, and progressive disease, and certainly not if they have a mental disorder that might affect their decision. The safeguards against coercion and exploiting a dying person have been strengthened, as have safeguards for disabled

[15] ibid

[16] Warlow, Charles. A new bill could legalise assisted dying in Scotland. BMJ 2024;385:q792. https://www.bmj.com/content/385/bmj.q792

> people who are not terminally ill and who have no wish to end their lives. The life ending medication will never be in public circulation and a healthcare practitioner will be present at the person's death. The patient must have had palliative care and hospice options explained to them. Clinicians can opt out of any involvement, just as they can with termination of pregnancy. There will be a robust system to record data on every patient, publicly available annual reports from Public Health Scotland, and a review of the legislation after five years."

There is no law against a person taking their own life in Scotland, and the law will not prosecute if a person supports another in going abroad to be assisted in dying, even when in full knowledge of the purpose. As noted in House of Commons Library, The Law on Assisted Suicide (July 2022)17:

> "Assisting a suicide in Scotland is not a specific offence, however people who are suspected of doing so could potentially be prosecuted for more general offences including murder, assault or offences under the Misuse of Drugs Act 1971. Unlike in England and Wales, there is no published prosecution policy specifically relating to cases where there is suspicion of assisted suicide in Scotland….In September 2021 Liam McArthur MSP proposed the Assisted Dying for Terminally Ill Adults (Scotland) Bill, which sought to "enable competent adults who are terminally ill to be provided at their request with assistance to end their life18….The consultation summary sets out that a "clear majority" of respondents (76%) were supportive of the proposal, with 2% partially supportive, 21% fully opposed and 0.4% partially opposed."[19]

The McArthur Scottish consultation also confirmed that:

> "Many believed a wider group of people should be able to choose an assisted death than the intended definition would allow for, such as those with potentially longer-term degenerative conditions, such as various neurological conditions and forms of dementia. A significant number of respondents also raised concerns about the proposal that the life ending substance must be self-administered, noting that some people who would wish to choose an assisted death would not be able to take the medicine themselves. Many respondents believed this to be

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[17] Assisted Dying/Assisted Suicide, Second Report of Session 2023–24: https://publications.parliament.uk/pa/cm5804/cmselect/cmhealth/321/report.html#footnote-397-backlink

[18] The Scottish Parliament, Proposed Assisted Dying for Terminally Ill Adults (Scotland) Bill – Liam McArthur MSP Summary of Consultation Responses (September 2022)

[19] ibid

> potentially discriminatory and called for a health care professional to be able to administer the drug in certain circumstances, or that there should at least be clarity on how life would be ended in such circumstances."[20]

In terms of justice, all sides would seem to agree that everybody should have a right to equal treatment and access to social support and medical resources. This point is particularly stressed by those supporters of AD who believe that those consenting individuals who are incurably suffering but unable to take a lethal dosage themselves, but wish to do so, should have a right to be assisted in the administration of the dose.

Assisted Dying has already been introduced in a range of other countries. The core question is whether there is sufficient evidence or public appetite to have clarifying and enabling legislation introduced that will allow specifically Medically Assisted Dying without the danger of subsequent prosecution. Only 6% of Scots think the current law in relation to AD in Scotland is working well.[21]

There now exists an abundance of evidence in support of AD, from peer-reviewed case-studies to meta-analyses and systematic reviews, some of which have led to the introduction of assisted dying in other states and countries. In addition, there are regular evaluations and reports to draw upon specifically published from already-established systems in other states and countries.

Assisted dying is already established in Belgium, Canada, Austria, Luxembourg, Netherlands, Oregon, Washington, New Jersey, New Mexico, Hawaii, Montana, Maine, Colorado, California, District of Colombia, California, Vermont and Switzerland. Spain, Portugal, Colombia, Ecuador, New Zealand, all six Australian states, and now the Isle of Man have legalised assisted dying, and legal support is also available in Colombia. New York Assembly passed the Medical Aid in Dying Act and Delaware passed the Ron Silverio/Heather Block End of Life Options Act (HB140) into law in May 2025.

The French government lower house recently passed a bill on assisted dying by a vote of 305 to 199[22]. Iceland, Cuba, Kentucky, Maryland, Massachusetts,

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[20] Ibid

[21] https://www.dignityindyingscotland.org.uk/wp-content/uploads/sites/2/2025/02/DiD_Inescapable_Truth_Scotland_WEB.pdf

[22] https://www.theguardian.com/world/2025/may/27/french-parliament-prepares-to-vote-on-legalising-assisted-dying

and Tennessee have introduced bills. Most recently Jersey has voted to introduce assisted dying, and a bill is working through Parliament for England and Wales. Legislation supporting death with dignity will be introduced this year in Scotland, Illinois, Indiana, Missouri, New Hampshire, Maryland, Florida, Kentucky, Tennessee, and Nevada.

In Switzerland and Germany there is an extensive practice of assisted suicide without explicit legislation.

Spain, the Netherlands, Belgium and Luxembourg have laws that allow not only people who are terminally ill but also those who are incurably and intractably suffering but not terminal to request and receive assistance to die.

The arguments for and against assisted dying have been around and mainstream for year. According to a range of recent surveys, around three quarters of the British public have consistently over decades supported the introduction of assisted dying as an additional choice within palliative care. The British Medical Association note that between 1983 and 2016, the British Social Attitudes Survey pegged UK public support for Assisted Dying consistently at 75% to 82%[23]. The National Centre for Social Research, in written evidence submitted to Westminster confirmed that:

> "There has been broad support for assisted dying/suicide for 20 years, particularly in the case of people with painful and incurable terminal diseases; support has strengthened in the case of people with painful and incurable diseases that will not kill them."[24]

A majority of British medical organisation have withdrawn their objection to assisted dying. A majority of those diagnosed with chronic conditions and/or disability also support the introduction of assisted dying.

In recent years the British public have in a clear majority supported assisted dying for individuals suffering unbearably and incurably from chronic irreversible conditions.

1.2 Demographic changes.

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[23] BMA (2023) Public and professional opinion on physician-assisted dying. https://www.bma.org.uk/media/4403/public-and-professional-opinion-on-physician-assisted-dying-report-v2.pdf

[24] https://committees.parliament.uk/writtenevidence/116429/pdf#:~:text=The proportion of respondents saying,(see Table 1 below).

As Will Self has observed:

> "We're living longer and longer, while our deaths are becoming commensurately more protracted. Such is the brilliance of contemporary medical science, at least in our privileged realm, that we can be kept breathing long past the point where our existence is anything save miserable - miserable for us, miserable for our loved ones, and miserable for those who have been appointed by either by the state or a private health plan to minister unto us. Many, I'm sure, will disagree, having had positive experiences of care and kindness in hearth and home and hospice, but these experiences are far from universal."[25]

Research findings published by the Journals of Gerontology confirm that rates of illness and disability increased across successive generations during the last century[26]. This is increasing and will continue to increase in the future.[27].

> "The Scottish population is ageing and in 2020, there were an estimated one million Scotland residents aged sixty-five years or older. By 2040, this will rise to an estimated 1.4 million, or 25% of our population….Currently in Scotland people aged over 70 years live with an average of three chronic health conditions."[28]

Living with numerous and often complex health problems is becoming the norm for older people and those from disadvantaged communities. Some conditions cluster together and people can experience many different

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[25] https://www.bbc.co.uk/news/magazine-20972525

[26] Gregory, Andrew (2024) *Baby boomers living longer but are in worse health than previous generations. Guardian.* https://www.theguardian.com/society/2024/oct/07/baby-boomers-living-longer-but-are-in-worse-health-than-previous-generations?CMP=fb_gu&utm_medium=Social&utm_source=Facebook&fbclid=IwY2xjawFwgkdleHRuA2FlbQIxMQABHS_OTmGcHGRFOd3dxHX17ZA9I8d4vW9J86sg1SmHNZJoTfCMAcxld8Kk3A_aem_fveSO8af7A6KY7Bs1VqPoQ#Echobox=1728281071

[27] Whitty, Chris (2023) *Chief Medical Officer's annual report 2023: health in an ageing society. Department of Health and Social Care:* p2. https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2023-health-in-an-ageing-society

[28] Scottish Government (2022) *Health and Social Care Strategy for Older People: Analysis of Consultation Responses* https://www.gov.scot/publications/health-social-care-strategy-older-people-analysis-consultation-responses/

combinations of conditions.[29] Long-term conditions or chronic diseases are conditions for which there is currently no cure, and which are managed with drugs and other treatment. The number of people with three or more long-term conditions (multi-morbidity) has also been increasing. A third of middle-aged UK adults have at least two chronic health issues. Prevalence of multimorbidity was high from mid-life (33.8% at age 46–48) in Britain[30].

People are living longer[31] [32], but many of these additional years are spent with health problems. In the most cases, palliative care as it currently exists in the UK proves sufficient to allow life to remain at least bearable. There is however a clear and significant subset of cases where the range of choice available is simply insufficient and/or unpalatable to chronic sufferers.

> "In 2016/17 there were about 57,000 deaths in Scotland, a figure set to rise slightly to just over 60,000 by 2037. Around 75% of these people will have needs arising from living with deteriorating health for the years, months or weeks before they die."[33]

1.3 The ethical and moral debate.

The concept of a 'natural death', in view of modern medical intervention, is for many at best anachronistic and illusory. Strinic[34] observes that

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[29] Imison, Candace (2021) *NIHR Evidence; Multiple long-term conditions (multimorbidity): making sense of the evidence.* doi:10.3310/collection_45881

[30] Gondek et al (2021) *Prevalence and early-life determinants of mid-life multimorbidity: evidence from the 1970 British birth cohort. BMC Public Health* volume 21, Article number:1319. https://doi.org/10.1186/s12889-021-11291-w

[31] Office for National Statistics (20213) *Profile of the older population living in England and Wales in 2021 and changes since 2011* https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/profileoftheolderpopulationlivinginenglandandwalesin2021andchangessince2011/2023-04-03

[32] Government Office for Science (2016) *Future of an Ageing Population*. https://assets.publishing.service.gov.uk/media/5d273adce5274a5862768ff9/future-of-an-ageing-population.pdf

[33] Scottish Government (2018) *Palliative and End-of-Life Care by Integration Authorities: advice note.* https://www.gov.scot/publications/strategic-commissioning-palliative-end-life-care-integration-authorities/pages/5/

[34] Strinic, Visna (2015) *Arguments in Support and Against Euthanasia*, British Journal of Medicine & Medical Research 9(7): 1-12. http://geographical.openscholararchive.com/id/eprint/998/1/Strinic972015BJMMR19151.pdf

> "Advances in medical technology means that people are living longer. The population is aging, and modern medicine has extended people's life span with the result that it is more likely now than in the past that the people will die of chronic degenerative diseases. Euthanasia has been a subject of controversy for more than three thousand years."

The original Hippocratic Oath, cited by opponents of AD, states, "I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous."

The original oath also states ""I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect". This is generally understood, but not without disagreement in some quarters, to be a reassurance that the doctor will be neither one of the many untrained 'quacks' and medical charlatans operating in that period, nor an assassin working for an enemy. The poison proviso has long since been removed from almost all modern oaths, along with other anachronistic maxims such as the restriction that only men should practice medicine, and the pledge to allow barbers to wield the scalpel and operate on the sick. After all, strict adherence to "no deadly drug" would bar any risky treatment involving anything with a possible lethal toxicity, and indeed any treatment that could be applied under the doctrine of 'double-effect'.

Euthanasia, a Greek word meaning "a good death" was practiced in ancient Greece before, during and after the introduction of the Hippocratic Oath. MacLeod, Wilson and Malpas observe that in Hippocrates' time and subsequently, self-administered deaths were permitted, and "some physicians were instrumental in helping terminally-ill or fatally injured individuals to die".[35] They note that "there is little doubt that throughout human history those charged with providing healthcare services have assisted very-ill individuals to die more rapidly than nature would have allowed".[36]

As Rothschild[37] observes:

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[35] Macleod et al (2012) *Assisted or Hastened Death: The Healthcare Practitioner's Dilemma*. Global Journal of Health Science; Vol. 4, No. 6; 2012. https://www.researchgate.net/publication/230817383_Assisted_or_Hastened_Death_The_Healthcare_Practitioner's_Dilemma

[36] ibid

[37] Rothschild, Alan. Physician-Assisted Death An Australian Perspective. From Giving Death a Helping Hand: Physician-Assisted Suicide and Public Policy. An International Perspective. Edited by DIETER BIRNBACHER and EDGAR DAHL 2008 Springer Science+Business Media B.V.

> "Medicine is a science that today would be incomprehensible to Hippocrates when he penned his oath so many years ago. Traditional medical ethics, as well as medical law, are lagging behind the progression of both medical science and patient autonomy, when they should be ahead or at least abreast of medical practice so that the medical profession has standards it can follow rather than improvise."

The original Hippocratic Oath has seen multiple revisions over the centuries, with each new contemporary version reflecting changes in medical and ethical practice. As of 1993, only 14% of medical oaths prohibited euthanasia.[38]

The 1964 adaptation by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University, and used in many medical schools today states:

> "I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of over-treatment and therapeutic nihilism."[39]

Since those ancient times science has advanced to the point that medical intervention can keep a person alive long beyond the natural death that would have occurred. The question persists: just because we can, should we keep those we love alive at all costs? Where does the notion of help stop and harm start? What do we do when continuing medical support and extending life is to the detriment of somebody who is incurably suffering? As Clarke & Egan[40] note:

> "The traditional role of the physician has been to preserve human life. However, we have now reached a stage where physicians are often accused of preserving human life long after life itself has become a burden to the person living it."

Currently the World Medical Association's revised International Code of Medical Ethics operates by the four fundamental ethical principles of *beneficence*, *non-maleficence*, *respect for autonomy*, and *justice/fairness*, as

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[38] Hajar, Rachel (2017) *The Physician's Oath: Historical Perspectives*. Heart Views 18(4):p 154-159, Oct–Dec. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5755201/

[39] Lasagna, Louis (1964) *The Hippocratic Oath: Modern Version*. https://www.pbs.org/wgbh/nova/doctors/oath_modern.html

[40] D L Clarke, A Egan. Euthanasia – is there a case? https://www.academia.edu/117086765/Euthanasia_is_there_a_case?email_work_card=view-paper

defined by Beauchamp and Childress, augmented by the two additional core ethical principles of *respect for human life* and *respect for human dignity*.[41]

Opponents of AD argue that palliative care is sufficient for all patients, and that the right to AD for some threatens the autonomy of others. They argue that the patient may be deprived of a valued future, that vulnerable people may be coerced or put at risk, and that any legal change is the start of a slippery slope. They argue that ending a life even if it appears compassionate is against the will of their god.

Supporters of AD argue that AD falls within the scope medical ethics. AD supporters see a commitment to beneficence and non-maleficence including helping incurable patients where existing treatments prove insufficient or causing more harm than good, and continued living is no longer beneficial. They see it as a means to avoid unnecessary excessive suffering. AD supporters argue that to support a request by a patient to end unnecessary and incurable suffering is an act that benefits. They argue that choosing to ignore such pleas and insist that the suffering continues can be seen to be to the detriment of the patient and therefore an act of malice.

To supporters of AD, a commitment to autonomy and respect for human dignity includes prioritising the patient's wishes and not inflicting unwelcome treatment and unnecessary suffering upon them. Choices by patients who choose to cease treatment or further intake of food and water are already respected, in the certain knowledge that death will follow. In such cases, where a brief release may not be possible, the subsequent experience can be unnecessarily traumatic for both the patient and their loved ones.

In terms of respect for human life, for supporters of AD this requires a recognition that situations exist where an acceptable quality of life ends and a drawn out death characterised by misery and intractable suffering begins.

41% of Scots have witnessed a dying family member or friend suffer unbearably towards the end of their life.[42]

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[41] Parsa-Parsi et al (2024) *The revised International Code of Medical Ethics unites doctors under one global medical ethos*. BMJ 2024; 384 doi: https://doi.org/10.1136/bmj.q449

[42] https://www.dignityindyingscotland.org.uk/wp-content/uploads/sites/2/2025/02/DiD_Inescapable_Truth_Scotland_WEB.pdf

46% of Scottish healthcare professionals have experience of caring for someone who has suffered at the end of their life despite receiving high quality palliative care.[43]

50% of doctors personally support changing the law on assisted dying.[44]

58% of doctors also believe, if the law were to change, people experiencing unbearable suffering with no prospect of improvement should be eligible for an assisted death. Only a minority of doctors (24%) think assisted dying should be restricted to people with six months left to live.[45]

62% of Scottish healthcare professionals believe there are circumstances in the UK in which doctors or nurses have intentionally hastened death as a compassionate response to a patient's request to end their suffering.[46]

Only 29% of Scottish healthcare professionals think refusing treatment to bring about death is more ethical than giving people the option of an assisted death.[47]

Only 14% of Scottish healthcare professionals think that without an assisted dying law there are sufficient options available to give dying people meaningful control over their deaths.[48]

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[43] https://www.dignityindyingscotland.org.uk/wp-content/uploads/sites/2/2025/02/DiD_Inescapable_Truth_Scotland_WEB.pdf

[44] https://www.mydeath-mydecision.org.uk/professional-and-public-opinion/

[45] https://www.mydeath-mydecision.org.uk/professional-and-public-opinion/

[46] https://features.dignityindying.org.uk/inescapable-truth-scotland/#:~:text=62% of Scottish healthcare professionals,at the end of life.

[47] ibid

[48] ibid

2 The legal position under current Scots Law.

There is insufficient clarity from Scots case law in relation to assisting a death where the motivation has been argued to be compassion. As Fakonti et[49] al observe:

> "The Scottish criminal law on the issue of assistance in dying is currently vague and unnecessarily complex. There is no specific criminal offence of committing or attempting to commit suicide, no separate offence to prohibit assisted suicide, and no offence-specific guidelines for prosecutors. Depending on the type of assistance provided, the charge could be murder, culpable homicide, or reckless endangerment."

An increasing number of states and countries have introduced Assisted Dying (AD) in attempt to offer the option to those who face an unbearable loss of dignity and quality of life due to chronic symptoms and intractable pain. As Michael Ashby notes:

> "There is an ongoing global conversation about dying, particularly with regard to treatment abatement decisions, causation and responsibility for death, and relief of physical and existential suffering…. On the one hand, the public (fed by a technically optimistic health industry) may have unrealistic expectations of curative capacity; on the other, they exhibit widespread concern about "bad dying".[50]

In Switzerland assisting suicide remains illegal, but only if the motive is selfish. If the motive is compassionate, there is no offence. In relation to the notion of bodily autonomy, Fontalis et[51] al note that:

> "within the jurisdiction of Swiss law, it includes a patient's choice to avoid what they consider an undignified and severe end to their life…it can be argued that respecting autonomy inherently involves the prima

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[49] Fakonti, C & Papadopoulou, N 2025, 'Choice, autonomy, coercion in Scotland's Assisted Dying for Terminally Ill Adults Bill 2024', *Edinburgh Law Review*, vol. 29, no. 1, pp. 162-168. https://researchonline.gcu.ac.uk/ws/portalfiles/portal/99210555/99187574.pdf

[50] Ashby, Michael (2016) *How We Die: A View From Palliative Care*. QUT Law Review Volume 16, Issue 1, pp5-21. https://lr.law.qut.edu.au/article/view/619/581

[51] Andreas Fontalis , Efthymia Prousali and Kunal Kulkarni. Euthanasia and assisted dying: what is the current position and what are the key arguments informing the debate?. Journal of the Royal Society of Medicine; 2018, Vol. 111(11) 407–413 DOI: 10.1177/0141076818803452 https://journals.sagepub.com/doi/pdf/10.1177/0141076818803452

facie right of a patient to control the circumstances and time of death by requesting help in dying. This could minimise the suffering of an individual or their family and improve the quality of the end of the patient's life, as their wishes would be respected and dignity would be preserved."

In the Netherlands and in Canada, a range of court-based legal precedents operated in defining both the law and appropriate legal sanctions. In England, such precedents may play a part in the current legislation before Westminster. Suicide was decriminalised in 1961 in England but encouraging or assisting a suicide, even where consent and request are evident, was specifically made illegal under the Suicide Act 1961. The DPP (under Keir Starmer) clarified that anybody accompanying a person travelling to Dignitas should not be prosecuted. And while Pretty v. U.K. confirmed that more active and direct assistance in ending a life remained illegal, cases where individuals charged with murder by claiming to be compassionately ending the lives of intractable suffering provided some clarity - Dr David Moor had administered multiple lethal doses but was able to cite the doctrine of 'double-effect' and was acquitted, while members of the public who killed a loved one who was intractably suffering, claiming consent, were not imprisoned for murder - Bernard Heginbotham received a community rehabilitation order, Brian Blackburn received a suspended sentence, and David March received a suspended sentence and 50 hours of unpaid work.[52]

By comparison, the laws relating to AD in Belgium and in Luxembourg, and likely in Scotland, have been Parliament-based and required more detail due to the lack of clear useful legal precedents. The key concept of justification in the Netherlands is based around the concepts of beneficence and necessity[53], while in Canada, the US and the UK, the core justifying concept leans more towards personal autonomy.

Scots law is a mixed legal system, drawing on both precedents established by case law and from civil law.

In Scotland, there is a dearth of clear and unambiguous court-ruling legal precedence, and the law differs from England. Laws relating to taking one's own life or supporting the request of a consenting person do not exist in

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[52] Kanellopoulou, Georgia Euthanasia in the UK and the need for a legislative change. https://www.academia.edu/25211206/Euthanasia_in_the_UK_and_the_need_for_a_legislative_change?email_work_card=view-paper

[53] LEWIS, PENNEY. The Dutch Experience of Euthanasia https://www.academia.edu/10763641/The_Dutch_Experience_of_Euthanasia?email_work_card=view-paper

Scotland. In addition, there are contradictory court rulings in relation to assisting a death. The case of Janet Johnson (*Law Hospital NHS Trust v Lord Advocate* 1996 SC 301), who was in a persistent vegetative state after a suicide attempt, as reported by Clare Dyer[54] in 1996, offered a degree of clarity in relation to the notion of 'futility' and the active involvement of medical staff in the ending of a life:

> "Lord Cameron of Lochbroom ruled that it was no longer in Janet Johnston's best interests to keep her alive. The way was cleared for the ruling after five senior judges held last month that a single judge could give permission for patients in persistent vegetative states to be allowed to die, though a civil court could not give doctors immunity from prosecution for murder. That obstacle was removed two weeks ago when Scotland's Lord Advocate, Lord Mackay of Drumadoon, issued a statement saying that doctors who allowed patients to die with court approval would not be prosecuted. The withdrawal of feeding would be handled with "care and sensitivity," he added. The nursing director, Bob Robertson, said that nursing staff caring for Mrs Johnston had agreed that she should be allowed to die."

It was stated in that case[55]:

> "It is not in doubt that a medical practitioner who acts or omits to act with the consent of his patient requires no sanction or other authority from the court. The patient's consent renders lawful that which would otherwise be unlawful. It is not for the court to substitute its own views as to what may or may not be in the patient's best interests for the decision of the patient, if of full age and capacity."

In other cases involving the ending of a life, the waters remain muddied. For example in 1996 Paul Brady[5657] smothered his brother after administering alcohol and pills, and walked free with a charge of culpable homicide and an admonition. However, in 2018 Ian Gordon[58] was convicted of culpable homicide and jailed for four years and three months for a "final act of love",

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[54] Dyer, Clare, legal correspondent, Scottish court gives right to die. BMJ VOLUME 312 4 MAY 1996. https://pmc.ncbi.nlm.nih.gov/articles/PMC2350638/

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

[56] BMJ 1996; 313 doi: https://doi.org/10.1136/bmj.313.7063.961 (Published 19 October 1996)

[57] https://www.heraldscotland.com/news/12085275.mercy-killing-brother-admonished/

[58] https://www.scottishlegal.com/articles/husband-jailed-culpable-homicide-mercy-killing-terminally-wife-admonished-following-appeal

although the sentence was quashed on appeal and an admonition substituted. Supporters of the status quo argue that the flexibility in sentencing is a strength. Detractors argue that despite what can be regarded as a correction of the original Gordon ruling upon appeal, Gordon nonetheless suffered the additional trauma not only of a trial but time in prison. In each case, a conviction of culpable homicide remained, a ruling that tends by definition to be of a killing that is reckless but unintentional. Neither case can comfortably described as a clumsy accident. The closest such rulings may come is to:

> "where death has resulted from the supply and/or administration of controlled drugs, the deceased having voluntarily ingested these."[59]

This, in effect, suggests that Brady and Gordon exist in the same legal space as drug-dealers.

Critics have argued that such vagaries strengthen the case for codification within Scots law by the Scottish Parliament.

Currently in Scotland, a person taking their own life is not illegal, and there is no specific crime of assisting a suicide in Scotland. But it is possible that helping a person to die could lead to prosecution for murder, culpable homicide or reckless endangerment."[60] As Warlow[61] notes:

> "In Scotland, unlike in the rest of the UK, it is not a specific criminal offence to help someone to end their own life. However, there is still a risk of prosecution for murder, culpable homicide, assault, and breach of the peace. As a result, any attempts to help a person die are necessarily covert, completely unrecorded, unregulated, and possibly abusive. The present legal situation is clearly untenable."

The most recent challenge seeking clarification within the current Scottish courts was initiated by Gordon Ross.

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[59] McDiarmid, Claire "Killings Short of Murder: Examining Culpable Homicide in Scots Law" in Alan Reed and Michael Bohlander (eds) Homicide in Criminal Law: A Research Companion (2019) 21 at 29. https://www.scotlawcom.gov.uk/files/4016/2202/9812/Between_Accidental_Killing_and_Murder_-_Culpable_Homicide_-_a_paper_by_Professor_Claire_McDiarmid.pdf

[60] https://www.dignityindyingscotland.org.uk/assisted-dying/the-law-on-assisted-dying-in-scotland/

[61] Warlow, Charles. A new bill could legalise assisted dying in Scotland. BMJ 2024;385:q792. https://www.bmj.com/content/385/bmj.q792

2.1 GORDON ROSS (petitioner) against LORD ADVOCATE (respondent).

In 2015, Gordon Ross challenged the Lord Advocate in court, claiming that the Lord Advocate had failed "to promulgate a policy identifying the facts and circumstances which he will take into account in deciding whether or not to authorise the prosecution in Scotland of a person who helps another person to commit suicide".[62]

Ross sought specific guidance from Scotland's Lord Advocate on criteria applied and likely outcome of assessment of cases of Assisted Dying, i.e. where one individual provided assistance to another in dying. The DPP in England had published clearer guidelines for prosecution or non-prosecution for such circumstances. The Lord Advocate's response was that this was not appropriate, as while under the European Convention on Human Rights the right to respect for private life encompassed respect for an individual's right to die, particularly to avoid an undignified and distressing death, was recognised, and the substantive law was not in breach of the petitioner's rights. The ruling confirmed that:

> "The function of the prosecutor is to secure the due application of the law, and nothing more. Any major change in the law is a matter for Parliament".[63]

Ross had expressed concern that if self-administration of a lethal substance remained less likely to attract prosecution but direct assistance in administration of a lethal substance could be more likely to attract prosecution, he and individuals in similar circumstances could feel pressurised to end their lives earlier than necessary by their own hands, and not later when physically incapable and requiring assistance. Ross argued that the lack of clarity placed undue stress upon sufferers and those who may seek to assist them in ending their lives.

The legal position remained that as no law specifically enables another person to assist somebody to end their life, discretion in relation to prosecution remains with the prosecutor, and assessment occurs after the attempt, not before, and on a case-by-case basis. The Prosecution code was regarded to allow sufficient scope and discretion to deal with such cases. An

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

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

example cited by the Lord Advocate was “Where a party freely travelled to another country with an individual who took a lethal drug to end their own life, there was no crime. If there was any form of duress, which was applied to the individual who required assistance, there may be a crime.”

Ross then petitioned for judicial review in the Court of Session seeking clarification from Lord Justice Clerk Carloway, Lady Dorrian and Lord Drummond Young on whether a person who helps another person to commit suicide would or should expect (foreseeability and accessibility) to be prosecuted under Scots law. Ross’s concern was that at the time where he may find life unbearable he would require assistance to take his own life. Again, Ross hoped to elicit similar new guidelines for (non) prosecution, primarily prosecution not being in the public interest, as had been produced in England by the DPP. Ross died before the ruling was published, and the appeal was unsuccessful overall, although it elicited further minor clarification.

2.2 GORDON ROSS (reclaimer) against LORD ADVOCATE (respondent), appeal as heard by Lord Justice Clerk Carloway, Lady Dorrian and Lord Drummond Young.

Lord Justice Clerk Carloway, Lady Dorrian and Lord Drummond Young heard the appeal and offered some key clarifications.[64]

Lord Drummond Young noted that in relation to the specificity sought by the petitioner, and in general, “absolute certainty is impossible. Every legal concept and every legal rule will inevitably be surrounded by a penumbra of uncertainty.”[65] He also confirmed a reluctance to engage in a change in the law led by the courts, noting that while “assisted suicide is a subject that, on any view, raises profound moral issues. It also raises very strong feelings, both for and against. In such a case it is in my opinion wholly inappropriate for the courts to attempt any major change in the law.” It is his view that the law is “a matter for legislators”.[66]

Lord Drummond Young further notes that while under Scots law suicide is not a crime, and in the case of an assisted death while “exceptional cases may exist where a prosecution will not be appropriate; in such cases the general

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[64] https://www.biodiritto.org/ocmultibinary/download/3033/29374/9/b701678c234eece5a1bd6ac39d5423c1.pdf/file/ross.pdf

[65] ibid

[66] ibid

discretion of the prosecution authority will be relevant."[67] However, he qualifies this by noting that each potential prosecution must be reviewed on its own individual merits. In the case of provided assistance, Drummond Young notes that various precedents in relation to causation can be applied in judging the level of direct causal link. The public interest and viability of any potential prosecution should remain at the discretion of the prosecutor, and can be expected in cases where sufficient admissible evidence is perceived to exist of murder or culpable homicide, or culpable and reckless conduct is suspected to have taken place.

Lady Dorian notes that "As parties have agreed, suicide is not a crime in the law of Scotland. Moreover, it seems that suicide has never been a crime in Scots law."[68] She notes however that under English law, it is an offence subject to imprisonment for up to fourteen years to seek to encourage or assist in the self-inflicted death of another, whether successful or not, and despite suicide itself being decriminalised in 1961. She notes that by contrast, "there is in Scotland no offence of 'assisted suicide'."[69] She further notes that "as the Dean of Faculty agreed during the hearing in this court, the clear situation of taking someone of sound mind and clear views to Switzerland to carry out a free and voluntary act would not even constitute the crime of culpable homicide in Scotland."[70]

Lord Carloway proposes that the petition "does not address the issue of "mercy killing" or euthanasia. It is restricted to acts of suicide which require some form of assistance from a third party."[71] Lord Carloway confirms the Lord Advocate's observation that neither taking one's own life nor attempting such are illegal in Scotland. The ruling also notes that "the criminal law in relation to assisted suicide in Scotland is clear. It is not a crime "to assist" another to commit suicide".[72] Clearly expressed and understood consent must however apply, and the degree of direct assistance and causality permissible retains limits. Assisting in the transport of a person to a location where they end their life would not qualify, for example. Placing a pill in the hand a consenting adult is permissible so that they can put it in their own mouth and therefore die by their own hand, but placing it in his or her mouth

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[67] ibid

[68] ibid

[69] ibid

[70] ibid

[71] ibid

[72] ibid

remains at best a grey area. Carloway argues that while administration of a lethal substance can qualify as homicide,

> "the voluntary ingestion of a drug will normally break the causal chain. When an adult with full capacity freely and voluntarily consumes a drug with the intention of ending his life, it is this act which is the immediate and direct cause of death. It breaks the causal link between any act of supply and the death.….In the same way, other acts which do not amount to an immediate and direct cause are not criminal. Such acts, including taking persons to places where they may commit, or seek assistance to commit, suicide, fall firmly on the other side of the line of criminality. They do not, in a legal sense, cause the death, even if that death was predicted as the likely outcome of the visit...There is no difficulty in understanding these concepts in legal terms, even if, as is often the case in many areas of the law, there may be grey areas worthy of debate in unusual circumstances. There is no need for the respondent to set these concepts out in offence-specific guidelines."[73]

Criteria that may support the possibility of action against any person who is seen to assist another in killing themselves, under current legal conditions, are sufficient evidence existing of an element of coercion, "undue influence, or other acts which could circumvent their will",[74] or indeed the perpetration of murder or culpable homicide. Other factors however may mitigate, such as "the age and circumstances of the victim, the attitude of the victim, and the motive for the crime".[75] In such cases, criminalisation may be legitimate and in the public interest where sufficient evidence of malfeasance exists. Each instance would not be considered for prosecution in an arbitrary manner, but assessed on a case-by-case basis, based on established criteria. As the ruling notes, "exactly where the line of causation falls to be drawn is a matter of fact and circumstance for determination in each individual case."[76]

Overall, the rulings confirmed no desire for the courts to make any substantive change or extrapolation in the law. That would remain a matter for the Scottish Parliament.

Ross argued that clarity was required. Dorrian concludes that the law meets the test for foreseeability, namely, that the ordinary citizen would: " ... be able

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[73] ibid

[74] ibid

[75] ibid

[76] ibid

– if need be with appropriate advice – to foresee, to a degree that is reasonable in the circumstances, the consequences which a given course of action may entail". Carloway clarified that

> "When an adult with full capacity freely and voluntarily consumes a drug with the intention of ending his life, it is this act which is the immediate and direct cause of death. It breaks the causal link between any act of supply and the death."

2.3 Does the status quo sufficiently serve the needs of changing Scottish population?

The rulings confirmed that any Scottish person has the right to attempt to end their own life. There is also no offence in Scotland of "assisted suicide" - it is not culpable homicide if clear consent was given. The decision to prosecute remains at the discretion of the prosecutor. Intention and consent along with public interest remain key criteria applied. However, ambiguity exists in Carloway's statement (and in the existing precedents in Scots Law in general) in relation to whether administering a lethal substance 'breaks the chain of causation' or may constitute a crime and is in the public interest to prosecute. The level of assistance given, therefore remains open to consideration for prosecutorial challenge, and indeed custodial sentencing.

As a response by Friends at the End to the The Scottish Parliament Cross Party Group on End of Life Choices[77] noted:

> "Scotland has failed to produce legislation to govern this area, condemning the legal landscape to 'an alarming lack of legal clarity', a situation described by Scots legal experts as 'shameful'. The Lord Advocate has refused to produce guidelines, stating that the Scottish prosecution code is suffice. It has been argued that the general prosecution code for homicide is not fit for purpose in the context of AD and that specific guidance should be offered. In Scotland, AD is governed by common law but had never been tested in the Scottish courts until Ross."

Any legal action if criminal activity (such as coercion) is suspected in a directly assisted death, is most likely to occur after-the-fact, once the main

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[77] Submission to the Scottish Law Commission on its tenth programme for reform, 2018-22. Accessed 21/04/25 https://www.scotlawcom.gov.uk/files/1815/0669/5167/35._CEO_Friends_at_the_End.pdf

witness is most likely already deceased. The law remains reactive, not preventative.

Where any person or persons who assisted another in dying are forced to make the case for their innocence in court, this can be a lengthy and very traumatic process. The process may also be vulnerable to harmful speculation, sensationalism and vexatious claims in public media.

Supporters of AD also argue that without a process introduced by law to medically monitor and assist individuals seeking assistance to end their own lives, such individuals can remain isolated, more vulnerable to coercion, and in danger of unpleasant deaths or deeply traumatising failed suicide attempts, or forced to end their lives prematurely.

The ambiguity in existing Scottish case law in relation to the culpability of anybody involved in the causation of the death of a consenting adult currently obstructs medical staff from openly assisting in the more compassionate death available to individuals in other countries. The current legal situation theoretically leaves medical staff open to (possibly vexatious) prosecution. The demand for clarification of the legal position in Scotland has grown significantly in over the years. Scottish courts have refused to make substantive changes to the law, hence the introduction of legislation to the Scottish Parliament this year.

2.4 Are there similarities between AD and existing medical practice in Scotland?

Any Scottish person can take another to Dignitas, or indeed drive them to a cliff knowing they will jump off, and the causal link is not seen as strong enough to lead to a successful prosecution.

Doctors in Scotland can withhold or withdraw treatment from a patient, where it is perceived to be futile, in the knowledge that the patient will die. In some cases this is against the wishes of the patient or the patient's guardians.

It is generally understood that some doctors have practiced, and will practice euthanasia. There exist multiple anecdotal sources, and various studies confirming that for compassionate and well-meaning reasons, medical professionals have chosen to curtail the unnecessary suffering of terminal patients. Doctors have been known to do this for other doctors suffering from an incurable condition with intractable pain.

As detailed in 'The Inescapable Truth About Dying in Scotland'[78]:

> "62% of Scottish healthcare professionals believe there are circumstances in the UK in which doctors or nurses have intentionally hastened death as a compassionate response to a patient's request to end their suffering at the end of life. A 2009 survey of doctors found that 28.9% had made decisions involving providing, withdrawing or withholding treatment that they expected would hasten the death of a person under their care. A further 7.4% reported they had made decisions with, to some degree, the intention to hasten a person's death. These decisions were more likely to be made when responding to a person's request for a hastened death. Some healthcare professionals discussed the possibility that former colleagues may have actively hastened death."

Some may see this as morally acceptable, but both the unregulated decision and the legal jeopardy are unacceptable. The lack of regulation and supervision can allow flawed practice to occur, as detailed by Magnusson[79]. The best interest of any patient and the medical practitioner is surely for any medical process to be subject to the strictures of legal regulation and professional administration[80].

Doctors also prescribe heavy doses of drugs in the knowledge that it can very likely be fatal, but can argue that it is in the interests of the patient. Fatal heavy sedation occurs in Scotland under what some regard as the fig leaf differentiation of "double effect". The claimed distinction between 'foreseeing death' and 'intending death' can be very narrow in practice. It can be argued that heavy/terminal sedation simply prolongs the death. Dr Erich H. Loewy suggests that some health professionals believe the doctrine of double-effect is a conceptual convenience, a narcissism of small difference that:

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[78] https://www.dignityindyingscotland.org.uk/wp-content/uploads/sites/2/2025/02/DiD_Inescapable_Truth_Scotland_WEB.pdf

[79] Magnusson, Roger. Euthanasia: Above ground, below ground. November 2004 Journal of Medical Ethics 30(5):441-6 DOI:10.1136/jme.2003.005090 https://www.researchgate.net/publication/8248731_Euthanasia_Above_ground_below_ground

[80] Sharma, BR. Assisted Suicide – How Far Justifiable? Chapter in Physician Assisted Euthanasia. Amicus Books, 2008: 65-85. https://www.academia.edu/4930108/Euthanasia_A_Dignified_End_of_Life_page_45_64

> ""lets them off the hook" ethically and "the belief that their ethical virginity has been preserved is, like Pontius Pilate's notorious symbolic hand washing, a dangerous delusion."[81]

As Professor Stephen Duckworth explains:

> "Being unconscious for medication to treat intractable pain is the same as being dead, and Continuous Deep Sedation (CDS) induces unconsciousness just as Assisted Dying causes death. So, the "Doctrine of Double Effect" does not establish a moral difference between CDS and Assisted Dying."[82]

Doctors in Scotland can administer heavy dosage that incurs a coma, and then continue to tend to the patient, in the knowledge that the patient will die either of overdose or as the body weakens and organs fail. Doctors in Scotland can also legally administer a lethal dose to a patient arguing that it was necessary to deal with the level of suffering, but that the death while foreseeable was not intended. Supporters of AD argue that the chain of causality is at best marginally different from direct supply of a lethal dose to a consenting patient. Proponents of AD also argue that there is sufficient equivalence between a decision to self-starve and dehydrate to die with medical support and supervision and the decision to take a pill to die in a more immediate manner to make one morally and ethically indistinguishable from the other.

The difference between acts and omissions to act remains a moral grey area at best. In relation to the Bland case in England and the Johnstone case in Scotland[83], Ferguson[84] notes that:

> "Lord Goff recognised this in the Bland case; he conceded that the drawing of a distinction between the giving of a lethal injection (an act)

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[81] Loewy, E. H. (2004). *Euthanasia, Physician Assisted Suicide and Other Methods of Helping Along Death. Health Care Analysis*, 12(3), 181–193. https://doi.org/10.1023/B:HCAN.0000044925.40069.C7 https://www.academia.edu/113873484/

[82] Duckworth, Prof Stephen (2022) *Written evidence submitted by Professor Stephen Duckworth OBE, DSc, PhD, FKC, MSc LRCP MRCS (ADY0002)* UK Parliament. https://committees.parliament.uk/writtenevidence/114065/pdf/

[83] Both cases involved patients in a persistent vegetative state where, in the absence of consent being able to be given by the patients, leave from the court was requested and granted to cease life-maintaining support. The Supreme Court in 2018 ruled that in England and Wales legal permission was no longer required to withdraw treatment from patients in permanent vegetative state.

[84] Pamela R Ferguson. Causing death or allowing to die? Developments in the law. Journal of Medical Ethics 1997; 23: 368-372 check!

> and the discontinuation of treatment (an omission) “may lead to a charge of hypocrisy". Lord Browne-Wilkinson also found the distinction between acts and omissions to be a difficult one. He said: "How can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks from lack of food but unlawful to produce his immediate death by a lethal injection. . . ? I find it difficult to find a moral answer to that question.”

However, existing cases in Scotland involving a consenting adult offer no clarity. This leaves medical staff potentially vulnerable to prosecution, if not conviction.

2.5 What legal options exist for those suffering from an incurable and intractable condition (or conditions) in Scotland?

As things stand in Scotland, a range of treatment is legally available for those enduring intolerable suffering:

2.5.1) to continue suffering unbearable pain and indignity, with palliative care providing whatever support it can under the law until death. While some of the best palliative support in the world is available in Scotland, it provides insufficient relief from suffering for some.

2.5.2) Medical staff can also decide to deny or withdraw treatment, independent of the patient’s wishes.

2.5.3) suicide attempt. Suicide is legal under Scots law. Some wish the process of ending their life to be an immediately effective process - they do not wish a slow dragged out experience of dying. Those who cannot afford to travel out of the country to seek formal medical assistance can attempt to end their life in isolation and without any medically proficient support. This can be botched and lead to further and greater suffering. Critics also feel that sufferers, to ensure that they are able to cause their own death without assistance, are forced to end their lives earlier than they would choose.

If the sufferer is assisted in ending their life, the limited case law available in Scotland remains ambiguous as to the legality of that assistance, and an investigation and possible prosecution may be instigated after the fact, where those who assisted will have to prove consent and lack of malfeasance in their personal motivation. Prosecution remains at the discretion of the prosecutor.

2.5.4) those who wish the reassurance of medical care and support for a quick and painless death can go to Dignitas or a similar foreign facility (those who can afford it and remain in sufficient health to be able to travel). This involves medical assistance. Any friend or family member who accompanies and supports the sufferer in travelling will not be prosecuted. As the Spectator notes:

> "The courts have ruled that doctors can withdraw life support from patients in a vegetative state. And Britons are free to travel to Switzerland for an assisted death. Between 2016 and 2022, about 400 people did so."[85]

Critics feel that sufferers, to ensure that they are able to travel, may feel compelled to travel when physically still able to, and as a result will end their lives earlier than they would otherwise have chosen.

2.5.5) heavy dosage drug administration insufficient to induce a full coma - a sufferer is condemned to losing themselves in a haze of drugs that steal dignity and quality of life via increasingly heavy sedation resulting in side effects such as nausea, vomiting, constipation, drowsiness, hallucinations, and an inability to communicate, comprehend or engage - a loss of dignity and a social death long before physical death. This involves medical assistance. Some sufferers, in particular those with cancer, in their final days or hours experience traumatic developments such as terminal haemorrhages, malignant fungating wounds, open stinking wounds, or a bowel obstruction and subsequent vomiting of faeces. Many sufferers do not wish to experience their final days in this degree of distress and discomfort, regarding that not as living, but as an additional punishment which augments rather than reduces their suffering. It can also prove traumatic for their loved ones.

2.5.6) heavy dosage drug administration involving an induced coma, where the dose is sufficiently heavy for death to be foreseeable. Medically referred to as "double effect" where the level of sedation required to alleviate suffering is "foreseen but not intended"[86] to cause death. This involves medical

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[85] https://www.economist.com/leaders/2024/11/21/why-british-mps-should-vote-for-assisted-dying

[86] The phrase "foreseen but not intended" is somewhat aspirational but also to some critics of the doctrine of double-effect somewhat disingenuous, somewhat akin to the ancient Romans washing their hands - such critics would argue that if the outcome is foreseen, then the choice is surely to a degree intentional. This grey area of interpretation has no doubt provided some medics the latitude to assist death without challenge, but such a lack of formal checks and balances remains a concern.

assistance, but it is argued that this does not qualify as an assisted death. Others see it as an unnecessarily prolonged death. The process risks the patient experiencing ICU delirium[87]. As noted by Sheen & Oates[88]:

> "The absence of physical responses should not be misinterpreted to mean that cognitive processes are not occurring."

In such cases of ICU delirium the sufferer is unconscious for the entire period, paralysed and non-responsive, and can no longer communicate or interact or wake up and change their mind. This persists until death. This imposes on their loved ones a traumatic and prolonged deathwatch, compounded by awful feelings of guilt for those who, for practical reasons, just cannot remain at the side of their loved to the end. Other than prolonging a bad death, the ethical distinction between this and a drug being administered by control and assent of the patient to provide a death at their time of choosing is difficult to see. A quicker death would appear more compassionate for all concerned.

2.5.7) refusal of food and water (see also 8.2). The law in Scotland already allows this particular version of assisted dying, enabled by the simple but common process of signing an advance directive form[89] - a Voluntary Refusal of Food and Fluid (VRFF)/Voluntary Stopping of Eating and Drinking (VSED) form.

Starvation and dehydration is a slow process, and it can take ten or more days for the sufferer to die. Bolt et al[90] found that "in 8% of cases, dying was a prolonged process of more than 14 days", while Quill et al[91] found that "The process of VSED until death may take up to 21 days". For those who choose

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[87] ICU Delirium - This is a common disorganised cognitive experience related to post-anesthesia, drug-withdrawal and to sedation. ICU is commonly experienced when awake, but also in an unconscious state where, invisible to anybody else, a person is apparently at peace but can actually be undergoing a deeply unpleasant and confused dream state.

[88] Sheen, L & Oates, J. A phenomenological study of medically induced unconsciousness in intensive care. Australian Critical Care Volume 18, Issue 1, February 2005, Pages 25-32. https://www.sciencedirect.com/science/article/abs/pii/S1036731405800219#preview-section-abstract

[89] As long as the form contains the required elements found in Advance Decision to Refuse Treatment forms and/or Do Not Attempt Resuscitation and/or Voluntary Refusal of Food and Fluid (VRFF)/Voluntary Stopping of Eating and Drinking (VSED) forms to specify what is and is no longer allowable.

[90] 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.

[91] Quill TE, Lo B, Brock DW. Palliative options of Last Resort: a comparison of voluntarily stopping eating and drinking, terminal sedation, physician-assisted Suicide, and Voluntary active euthanasia. Springer Science + Business Media B.V.; 2008.

to remain conscious, it can be an unpleasant way to die, in addition to their already chronic suffering.

2.5.7.1 VSED is commonly, but not always, accompanied by an induced coma. The sufferer will starve and dehydrate to death or succumb to an overdose, whichever occurs first as the body weakens. For those who agree to an induced coma, this involves clear medical assistance. In this case, death is both foreseeable and intended, which somewhat contradicts any claim of "double effect". Again, the death is prolonged, and the sufferer may experience ICU delirium. Pope and West[92] note that while some undergoing VSED may experience euphoria and tranquility, others have been observed to experience delirium or anxiety. That patients can experience such delirium from both a refusal of food and water and from the drugs used to induce a coma leaves some doubt as to the hope of a peaceful and dignified nature of the process as actually experienced by the paralysed patient. In the absence of access to a more direct assisted death, it has nonetheless become a common, if clumsy, euthanasia choice in many jurisdictions. As Quill & Byock[93] note:

> "When unacceptable suffering persists despite standard palliative measures, terminal sedation and voluntary refusal of food and fluids are imperfect but useful last-resort options that can be openly pursued."

It remains clear that this current 'imperfect' 'last-resort' process is problematic. As Pope and West[94] note:

> "One recent meta-review[95] concluded that "VSED has hardly been examined in the past 20 years." The authors describe the available articles as 'heterogenous and inconclusive,' representing a 'patchwork rather than a picture.' Indeed, VSED has been under-examined compared to other end-of-life options."

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[92] Thaddeus Mason Pope and Amanda West, "Legal Briefing: Voluntarily Stopping Eating and Drinking," The Journal of Clinical Ethics 25, no. 1 (Spring 2014): 68-80.

[93] Timothy E. Quill, MD, and Ira R. Byock, MD. Responding to Intractable Terminal Suffering: The Role of Terminal Sedation and Voluntary Refusal of Food and Fluids. Position Paper for the ACP–ASIM End-of-Life Care Consensus Panel. https://www.acponline.org/sites/default/files/documents/clinical_information/resources/end_of_life_care/intractable_suffering.pdf

[94] Pope, TM & West, A. Legal Briefing: Voluntarily Stopping Eating and Drinking. The Journal of Clinical Ethics 25, no. 1 (Spring 2014): 68-80. https://www.researchgate.net/publication/261996427_Legal_briefing_Voluntarily_stopping_eating_and_drinking

[95] N. Ivanovic, D. Bueche, and A. Fringer, "Voluntary Stopping of Eating and Drinking at the End of Life—A 'Systematic Search and Review' Giving Insight into an Option of Hastening Death in Capacitated Adults at theEnd of Life," BMC Palliative Care 13, no. 1 (2014).

In addition to doubts that may remain about the peaceful and humane nature of the process for the dying patient, the process can also be a prolonged and traumatic deathwatch for their loved ones. As the outcome is both foreseeable and intended, a common question is why such assisted deaths need to be dragged out for the sufferer and their loved ones when supply and/or administration of a more immediately lethal dosage could allow a more compassionate and shared goodbye, as is available in other countries.

A chronic sufferer can legally refuse medical treatment to die, and this may be a drawn-out process. A patient can also request no further treatment, in many cases an unpleasant way to die. A chronic sufferer can also request no further food or water. Palliative staff will comply and actively withhold or withdraw treatment. Professor Stephen Duckworth explains:

> "Currently dying people and non-dying people, (e.g. those in a permanent vegetative state or with locked-in syndrome, or people at the end stage of motor neurone disease, Multiple Sclerosis, and many other conditions) can refuse treatment such as oxygen, chemotherapy, or dialysis. If they are not receiving medical treatment, they are permitted to stop eating food or drinking water and this results in a long, slow, cruel death. But this is the only option they can take if they want to die."[96]

As Jackson[97] observes:

> "Given that there are a number of lawful ways in which patients' lives might be shortened by their doctors, what would be wrong with also permitting doctors to end life painlessly with a single lethal injection?"

In the latter examples above, the degree of active medical collaboration or assistance involved may vary, but it exists. It can certainly be argued that the difference between a patient requesting no further treatment, or no further food or water, and requesting a final pill or injection, when the desired and achieved outcome in each case is to end life, seems marginal. Supporters of AD would argue that the most significant difference is that the pill or injection avoids unnecessary dragging out of the process.

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[96] Duckworth, Prof Stephen (2022) *Written evidence submitted by Professor Stephen Duckworth OBE, DSc, PhD, FKC, MSc LRCP MRCS (ADY0002)* UK Parliament. https://committees.parliament.uk/writtenevidence/114065/pdf/

[97] Jackson, Emily and Keown, John. Debating Euthanasia Hart, Oxford, 2012 (reprinted 2013 & 2014): 13

While opposition to any form of assisted dying persists in some quarters, both suicide and these forms of 'assisted' dying have existed legally for some time in Scotland. The main law-related obstacle to a compassionate medically assisted death is the paucity of relevant case law in relation to supplying or administering of a lethal dose by a medical practitioner as part of a requested assisted death.

Arguments advanced for assisted dying have covered areas as diverse as the right to freedom from torture, the right to privacy, the right to autonomy and self-determination, the right to dignity, or indeed the right to have access to equality. Currently the key issue to be clarified, and addressed by the Assisted Dying for Terminally Ill Adults (Scotland) Bill, is whether a doctor can prescribe and/or supply a lethal dosage to a consenting patient for self-administration.

Any assisted death process as outlined in the current Scottish proposals will be detailed, thorough, tightly regulated, monitored and controlled. Participation will be voluntary.

The current legislation being introduced to the Scottish Parliament will address ambiguity in relation to supply (but not administration) of a terminal dose if passed. The proposal limits assistance to die to those who are terminally ill, and excludes others who are likely to be suffering equally, or more so, but over a longer period before dying. As the 2025 Joint Report of the Theological Forum and the Faith Action Programme Leadership Team on Assisted Dying[98] acknowledges:

> "Those eligible for assisted dying under the current proposals—those with an advanced and progressive disease, illness or condition from which they are unable to recover and that can reasonably be expected to cause their premature death—are not choosing between life and death, but between two types of death."

[98] Church of Scotland. Joint Report of the Theological Forum and the Faith Action Programme Leadership Team on Assisted Dying. 2025. https://www.churchofscotland.org.uk/__data/assets/pdf_file/0004/133645/Volume-of-Reports-2025.pdf

2.6 The Assisted Dying for Terminally Ill Adults (Scotland) Bill

“A person is terminally ill if they have an advanced and progressive disease, illness or condition from which they are unable to recover and that can reasonably be expected to cause their premature death.”

The person (declarant) requesting AD must be:

1) a resident for at least 12 months in Scotland and registered with a Scottish medical practice, and has capacity to make a declaration - a request for AD.

2) made aware of prognosis and all other palliative options to consider

3) made aware of the AD process

4) made aware that they may choose not to go forward with AD at any time

5) be assessed for eligibility by medical practitioners.

The coordinating practitioner must:

1) confirm the eligibility of the declarant

2) take steps to confirm the prognosis and capacity with specialists if required

3) inform the practitioner with whom the declarant is registered throughout

4) consult with those close to the person

5) take steps to confirm there is no coercion

6) refer the declarant for an independent second assessment by a separate medical practitioner.

The process involves a first declaration, witnessed by the original coordinating medical practitioner, followed by a period of 14 days for reflection, and then a second declaration by the patient and confirmed/ witnessed by the coordinating medical practitioner and the other independent medical practitioner.

A declaration can be signed by the applicant via proxy (solicitor, member of Faculty of Advocates or a justice of the peace). The declarant can also withdraw from the process at any time.

The medical professional supplying the substance will remain with or near the patient. If the process completes, the medical professional will record the death and produce a report, and inform the declarant's GP.

There will be an annual report (to be published) collating data and statistics, plus a review.

No medical professional need participate if unwilling.

Anybody found guilty of coercion is liable to a sentence between 2 and 14 years and/or a fine.

2.7 Summary

The law as it currently stands has not and will not stop those determined to end their life, but legislation could provide significantly greater care, and significantly reduce the likelihood of tragic mishaps.

Many intractable sufferers simply want the reassurance and peace of mind of choice and do not in fact make use of the option at the end.

2.7.1 Under Scottish law, ending your own life is already legal.

2.7.2 A person in Scotland can already legally travel to another country to end their life. This option remains open, even if legal, only to those Scots who can afford it, and therefore remains a matter of exclusion, unfairness and inequality.

2.7.3 A person in Scotland can also already accompany, provide transport, finance and support for an individual to travel to the location where they end their life, without risk of a conviction, and little likelihood of an attempt to prosecute.

2.7.4 Medical staff in Scotland can already legally refuse or withdraw life-maintaining treatment.

2.7.5 Medical staff in Scotland can already legally administer a heavy drug dosage in the knowledge that it will remove any ability of the patient to

meaningfully engage with life before they die. Supporters of AD have argued that in some circumstances this does not meaningfully extend life, but simply extends the death.

2.7.6 Medical staff in Scotland can already legally administer a heavy drug dosage in the knowledge that it may be likely to cause the death of the patient.

2.7.7 Medical staff in Scotland can already legally assist a patient in ending their own life by dehydration and starvation by administering drugs to induce a coma, and will provide palliative care until the patient dies of deterioration of organ function or overdose as they weaken. Patients will tend to die within two weeks in this process. No cases of coercion have come to light in all the time that this process has been undertaken by Scots. Supporters of AD argue that this process does not meaningfully extend or protect life, but simply extends each death unnecessarily, and inflicts a traumatic deathwatch on the dying patient's loved ones. An outcome of death is both foreseeable and intended, but is unnecessarily drawn out in comparison to the provision of a lethal dose that would allow a goodbye surrounded by loved ones.

2.7.8 The crux of the matter is in the existing ambiguity in relation to notions of proximity to causality and definitions of acceptable assistance. Provision of a lethal dose to a consenting adult, where death is both foreseeable and intended, even for clearly compassionate reasons, remains a grey area that leaves doctors, palliative nurses and health organisation at risk of prosecution. At best, each case must be examined and considered for prosecution for murder or culpable homicide, or culpable and reckless conduct, on a case-by-case basis, and on the basis of public interest, provable consent, intent and evidence of malfeasance.

Lord Carloway and his colleagues offered theoretical examples based on limited existing case law. They also make clear that anything further is a matter for Holyrood.

A theoretical example offered by Carlaw - that of driving a person who intends to jump off a cliff to the cliff - remains nonetheless ambiguous. What if the driver helps the person out of the car if they struggle with mobility? What if the driver helps them to the edge of the cliff - analogous to placing a lethal pill within reach? What if the sufferer is incapacitated and requests a nudge - analogous to medical staff administering the dose? There is insufficient clarity from court rulings to provide clear precedence, and in the absence of specific Holyrood legislation, ambiguity remains in terms of what

should qualify as an acceptable level of compassionate provision of assistance to a consenting other to die.

3) Opposition to Assisted Dying.

The strength of feeling, although consistently a minority view, amongst those who oppose assisted dying is undeniable. Key arguments against AD are noted by Materstvedt et al[99]:

> "If euthanasia is legalized in any society, then the potential exists for: (i) pressure on vulnerable persons; (ii) the underdevelopment or devaluation of palliative care; (iii) conflict between legal requirements and the personal and professional values of physicians and other healthcare professionals; (iv) widening of the clinical criteria to include other groups in society; (v) an increase in the incidence of nonvoluntary and involuntary medicalized killing; (vi) killing to become accepted within society."

The perennial arguments opponents promote deserve scrutiny. As a compassionate nation the Scottish people can interrogate how best to achieve alleviation of terrible suffering. At this time of writing, the debate has already begun in Westminster and will soon reach Holyrood and the arguments will be replayed out in our media.

3.1 Opponents

A range of well-organised and well-funded pressure groups continue to oppose assisted dying. Key UK opposition groups are Our Duty of Care, Care Not Killing, and Right To Life UK. Disability Rights UK, Disability Equality Scotland and the British Geriatrics Society also oppose Assisted Dying legislation. The Church of Scotland, the Catholic Church in Scotland, and the Scottish Association of Mosques also oppose Assisted Dying. The campaign against the Scottish legislation has also had contributions from opponents from other countries.[100] The Telegraph, The Times and The Mail have also been vociferous in their opposition, and give the impression that the level of support for both sides of the debate is much more even than polls indicate.

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[99] Materstvedt et al. Euthanasia and physician-assisted suicide: a view from an EAPC Ethics Task Force. Palliative Medicine 2003; 17: 97-101. https://www.researchgate.net/publication/10798732_Euthanasia_and_Physician-Assisted_Suicide_A_View_from_an_EAPC_Ethics_Task_Force

[100] https://www.humanism.scot/2024/11/27/we-write-to-the-herald-over-inaccurate-assisted-dying-article/?fbclid=IwY2xjawHCXkRleHRuA2FlbQIxMQABHZCvWulXj2YBk0teEYXAA4V6_dDhiZLRO_bfzwdJRyYQlRdoJmF_m_0cvg_aem_ha6bv6Jsu9SoFVAAj5OSNQ#AssistedDying

3.2 Concerns about opposition claims and finance

Claims have been made that there are contrived “grass-roots” opposition groups that represent, and are funded by right-wing religious groups[101].

Amy McKay, an associate professor of political science at Exeter University, said the “grassroots” campaigns appeared to be a clear example of astroturfing – the practice of disguising an orchestrated campaign as a spontaneous outpouring of public opinion:

> “They’re giving this false impression that they are someone they’re not,” she said. She said using doctors to front a campaign motivated by religious interests was a “common tactic” that gave it added legitimacy. The effect was one of “manufacturing” the impression that more people were opposed to reform than is the case in reality, she said. “It makes it seem like the issue is much more closely divided than I think it really is.”[102]

Supporters of Assisted Dying claim a wide range of cherry-picked information, misinformation[103] and disinformation[104] [105] has been circulated by opponents.

Barbara Wagner in Oregon[106] 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 provider to reject the treatment in question. In the US medical insurance operates on differently priced tiers, and as a low wage earner (articles confirmed a series of low-paid

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[101] https://www.theguardian.com/society/2024/nov/16/revealed-grassroots-campaigns-opposed-to-assisted-dying-financed-by-conservative-christian-pressure-groups

[102] ibid

[103] For examples: https://deathwithdignity.org/resources/debunking-myths/

[104] For examples: https://deathwithdignity.org/resources/refuting-misinformation/

[105] Humanist Society Scotland (2024) *Humanist Society speaks out on underhand tactics used by opponents of assisted dying*. https://www.humanism.scot/2024/10/07/humanist-society-speaks-out-on-underhand-tactics-used-by-opponents-of-assisted-dying/

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

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. 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."[107]

An example cited in Canada was cited by Schuklenk[108]:

> "A little-known Canadian on-line journal called Current Oncology published – curiously timed for the BC Supreme Court proceedings – a piece by Jose Pereira (2011), an Ottawa-based anti-euthanasia campaigner and senior palliative care specialist. The on-line journal ran the article at the time as a regular article, implying that it underwent anonymous peer review. Jocelyn Downie et al.(2012) undertook a line-by-line analysis of said article, as also published in said journal. It turned out to be the case that many of Pereira's claims were not only not backed by the references he chose to insert, but that literature he cited actually reached conclusions different to those he reported."

Pereira's article was widely quoted and cited in evidence opposing AD. In response to concerns about the work of Pereira and others presented in opposition to AD, Jocelyn Downie et al[109], describing the work as "smoke and mirrors" observed that it is:

> "particularly important that the academic literature be rigorous so that the public policy debate can be informed by facts and not misshapen by smoke and mirrors. . . . The issue of the legalization of euthanasia and assisted suicide in Canada and elsewhere is complex and controversial. As various actors in the legal system contemplate reform, it is essential that they and the public they represent (in direct and

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

[108] Schuklenk, Udo. Assisted Dying in Canada Healthcare Papers Vol. 14 No. 1 42 https://www.academia.edu/9188749/Assisted_Dying_in_Canada?email_work_card=view-paper

[109] Jocelyn Downie et al, "Pereira's attack on legalizing euthanasia or assisted suicide: smoke and mirrors" (2012) 19 Current Oncology 133 at 134 and 137. https://digitalcommons.schulichlaw.dal.ca/cgi/viewcontent.cgi?article=1682&context=scholarly_works

> indirect ways) be well-informed. Carelessly researched and inadequately referenced or deliberately misleading professional journal articles with the apparent legitimacy of peer-reviewed literature must not be allowed to contaminate the debate. There is far too much at stake."

Another Canadian case, much cited by AD opponents is that of Rose Finlay[110] [111] 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 used to complain about delays in the provision of disability support, and Rose Finlay is still very much alive.

Downar et al noted:

> "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"."[112]

It can perhaps be assumed that those opponents of AD learned after that to wait until the people they chose to cite as examples of flaws in the AD system were no longer around to contradict their claims. Other cases cited by opponents have been found to be misrepresented[113]. Schuklenk describes the claims of opponents (in Canada) as follows:

> "Essentially, it is a propaganda war between a fairly small band of deeply religious and well-organized opponents of assisted dying and

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[110] 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

[111] 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

[112] 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/

[113] https://deathwithdignity.org/resources/refuting-misinformation/

> mostly secular proponents of a change in legislation. Opponents today hide behind a gaggle of secular names to hide their religious backgrounds. Their arguments have also switched from their traditional "God doesn't permit assisted dying" to various public reason-based arguments."[114]

Bernheim and Raus[115] echo a common criticism of opponents of AD, that they exhibit a

> "disregard of empirical evidence, appeals to canonical and questionable definitions, prioritisation of caregiver perspectives over those of patients".

A common strategy in modern campaigning can be a 'gish gallop' - a deluge of misinformation and disinformation claims that simply overwhelms attempts by politicians, the public and journalists to fact-check contemporaneously.

By comparison, a broad range of peer-reviewed research has been required to support and make the case for the introduction and implementation of assisted dying legislation.

A significant lacuna persists in reliable research data to support the arguments opposing assisted dying. Commenting on the empirical evidence from the Netherlands and the US State of Oregon, Professor Raymond Tallis of the Royal College of Physicians, states that:

> "Every single one of those assumptions is false."[116]

In Scotland, 'Protecting the vulnerable', 'supporting the NHS' and 'slippery slope' simply play better than 'I want you and those you love to suffer for my beliefs'.

It is therefore useful to examine the substance of the propositions posed by opponents of assisted dying.

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[114] Schuklenk, Udo. Assisted Dying in Canada, Healthcare Papers Vol. 14 No. 1 42 https://www.academia.edu/9188749/Assisted_Dying_in_Canada?email_work_card=view-paper

[115] Bernheim, JL & Raus, K (2016) *Euthanasia embedded in palliative care. Responses to essentialistic criticisms of the Belgian model of integral end-of-life care.* Journal of Medical Ethics; 43:489-494. https://jme.bmj.com/content/43/8/489

[116] ibid

3.3 Survey results relating to support and opposition to AD

In the most recent British Social Attitudes Survey[117], 79% of the public supported Assisted dying. In the previous year's survey, 78% supported AD.

58% of doctors believe that, if the law were to change, patients with physical conditions causing intolerable suffering which cannot be relieved should be able to access an assisted death.[118]

The religious groups that oppose assisted dying do not represent the majority of religious people. 80% of religious people in the UK support a change in the law to allow assisted dying.[119]

In one extensive survey, only 8% of disabled people surveyed believed that disability rights groups should maintain their opposition to assisted dying, while 79% supported a change in the law[120]. Another survey revealed that 87% of people who identify as disabled support assisted dying reform for people who are intolerably suffering.[121]

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[117] British Social Attitudes Survey, cited 18 Match 2025, https://humanists.uk/2025/03/18/overwhelming-public-support-for-assisted-dying-public-mood-unchanged/

[118] https://www.mydeath-mydecision.org.uk/professional-and-public-opinion/

[119] Sherwood, Harriet (2023) *Religious leaders 'out of step with flocks' on assisted dying, says UK rabbi.* Guardian. https://www.theguardian.com/society/2023/jul/03/religious-leaders-out-of-step-with-flocks-on-assisted-dying-says-uk-rabbi-jonathan-romain

[120] https://www.bbc.co.uk/news/blogs-ouch-28311809

[121] https://www.mydeath-mydecision.org.uk/professional-and-public-opinion/

4) Is introducing assisted dying a slippery slope?

The Oregon Death with Dignity Act, passed in 1994, is one example of a piece of legislation that has stood, virtually unchanged, for 30 years. The Canadian model, often held up as an illustration of gradual widening and loosening of eligibility criteria, is not an appropriate comparator as the situation experienced in Canada following the ruling in Carter v. Canada ([2015]1 SCR 331 - Carter v. Canada (Attorney General) - SCC Cases) could not happen in Scotland. The model it uses is not the terminal illness model used in the Bill, and the constitutional position of the Canadian Supreme Court is fundamentally different. In Carter, the Supreme Court of Canada declared that the blanket ban under s. 241(b) of the Criminal Code of Canada was unconstitutional and a breach of the Canadian Charter of Rights and Freedoms (specifically the right to life, liberty, and security of the person under s7). As a result, Bill C-14 was introduced to allow for Medical Assistance in Dying (MAiD). This was initially a more restrictive law, which was subsequently expanded further, in order to implement the original judgment in Carter.

This mandated introduction, and then subsequent widening of a statute is a particular feature of the Canadian constitutional arrangement which could not be replicated in Scotland. And even if a future Scottish Parliament were to consider changes, the 'legislative creep' that could effect change to eligibility criteria would have to go through the same robust parliamentary process as any other Bill. Gradual and increasing loosening of criteria specified in an Act is not a foregone conclusion, and the law can and does stand as a bulwark against sliding down the slippery slope.[122]

4.1 A slippery slope?

Emily Jackson[123] details tree types of slippery slope:

1) logical slippery slope
2) empirical slippery slope - poor practice claimed in countries with AD proves that disintegration and abuse are inevitable

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[122] Sivers, Sarah. *Clarity, compassion and choice — what next for Assisted Dying for Terminally Ill Adults (Scotland) Bill and why status quo is 'anything but safe'. Law Society of Scotland Journal. 15th May 2025. https://www.lawscot.org.uk/members/journal-hub/articles/clarity-compassion-and-choice-what-next-for-assisted-dying-for-terminally-ill-adults-scotland-bill-and-why-status-quo-is-anything-but-safe/*

[123] Jackson, Emily and Keown, John. Debating Euthanasia Hart, Oxford, 2012 (reprinted 2013 & 2014): 53-62

3) psychological slippery slope - once we become accustomed to the idea of AD “it becomes easier for society to take further steps to actively end the lives of those whose life has become not worth living or who deserve a dignified exit.”

The logical slippery slope is not necessarily very logical. It makes an assumption that expansion is inevitable. When the legalisation of gay marriage was proposed, some opponents argued that it would be a slippery slope to polygamy, incest and bestiality[124] [125] [126] [127]. In the case of AD, nothing will pass into law that is not the settled will of the people and supported by a majority of elected politicians. As Oregon has proven over the years, neither expansion nor contraction are inevitable.

With the second classification, the empirical slippery slope, this will continue to be open to any anecdote or claim of abuse or issue that is identified within monitoring and reporting being presented as proof of degradation within or of the system. Correlation is not the same as causality. Finding poor practice in any area of medicine does not equate to a negation of the value in general of that area of medicine. We do not shut down all post-natal care units in hospitals because of issues found in one. Most systems, as instituted, are subject to regulation, evaluation and iterative improvement.

In seeking to make a case for the existence of a slippery slope Woodruff (for The International Association for Hospice and Palliative Care)[128] for example cites examples without context or comparison with similar practices within health systems that do not practice AD. He includes decisions as part of his dataset which are controversial but are common in jurisdictions where AD remains illegal, such as withdrawal of medical support in futile cases, withdrawal of medical support in cases where a patient can no longer give consent, terminal sedation/double-effect and of course iterative adaptation and change in the law.

As for the third type, the psychological slippery slope, this assumes that such legislation is accepted by the public with such positive alacrity that they will

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[124] https://slate.com/news-and-politics/2004/05/slippery-slop.html

[125] https://uknowledge.uky.edu/law_facpub/459/

[126] https://epgn.com/2013/11/21/24095589-the-end-of-the-slippery-slope/

[127] https://www.bbc.co.uk/news/magazine-33463436

[128] https://iahpc.org/resources/publications/euthanasia-and-physician-assisted-suicide/euthanasia-and-physician-assisted-suicide-are-they-clinically-necessary-or-desirable/#arguments-for-and-against-assisted-dying 22/04/25

become desensitised to killing and more killing will inevitably be demanded. There was no pre-existing legal euthanasia Germany before Aktion T4 and as Emily Jackson points out[129], the Nazi mass murders (much cited by opponents of AD) were not motivated by the desire to treat compassionately those suffering intractably, but by a vile bigoted eugenics extermination doctrine. However, as an example, Woodruff[130] cites the journalist Wesley Smith's comparison of AD to murderous practice in Nazi Germany. As Schuklenk[131] argues:

> "How one moves from a "voluntary autonomous request" in a liberal democracy to "murdered-against-their wishes" does escape me, to be honest. What does the evidence tell us? A major survey of assisted dying practices in Belgium, Luxembourg, the Netherlands, Switzerland, Oregon, Washington and Montana concluded in 2013 that "the average person requesting assistance in dying is an elderly, well-educated, middle-class cancer patient"(Stecketal.2013). With regard to the Netherlands, a favourite target of opponents of assisted dying, a large study from the country, published in the leading medical journal The Lancet, concluded that "there is no apparent disproportionate use [of Assisted Dying in the Netherlands] in vulnerable populations"(Lo2012)."

In terms of the psychological slippery slope, it is also worth noting that many laws are not adopted with alacrity, but in reality tolerated by the public with a level of pragmatism, possibly even continuing discomfort. Legal does not mean loved.

As Jackson[132] concludes:

"The slippery slope claim is not that it would be *challenging* to regulate euthanasia effectively, but rather it would be *impossible*. Without more persuasive evidence, hypothetical and pessimistic speculation about our

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[129] Jackson, Emily and Keown, John. Debating Euthanasia Hart, Oxford, 2012 (reprinted 2013 & 2014): 53-62

[130] https://iahpc.org/resources/publications/euthanasia-and-physician-assisted-suicide/euthanasia-and-physician-assisted-suicide-are-they-clinically-necessary-or-desirable/#arguments-for-and-against-assisted-dying 22/04/25

[131] Schuklenk, Udo. Assisted Dying in Canada, Healthcare Papers Vol. 14 No. 1 42 https://www.academia.edu/9188749/Assisted_Dying_in_Canada?email_work_card=view-paper

[132] [132] Jackson, Emily and Keown, John. Debating Euthanasia Hart, Oxford, 2012 (reprinted 2013 & 2014): p62

inability to regulate euthanasia does not offer adequate justification for a refusal to contemplate what effective regulation might involve."

Schuklenk et al[133] distinguish the claims of AD opponents as

> "two basic forms of slippery slope argument. Both types are present in the assisted suicide and voluntary euthanasia debate. Some slippery slopes are *conceptual*. They claim the concepts used to set up criteria governing a practice are fuzzy, and that this conceptual vagueness will lead to the practice being abused. Others are *causal*. They claim that if a certain decision or policy is implemented, that could in and of itself be morally acceptable, causal mechanisms will be put in motion that will unavoidably lead to making other, much more morally dubious, decisions."

Schuklenk et al note that opponents of AD will argue that in the notion of 'competence' there's no fixed point of definition, and therefore there will be variations and outliers that may include the 'less competent'. Opponents also argue that such looseness will be open to abuse. This is countered by the argument that while there remains no perfect system in medicine, experienced professionals will be involved, who have a practical understanding of the established paradigms and guidelines.

As for 'causal slippery slopes', where opponents argue that the introduction of even a very limited form of assisted dying must inevitably lead to further expansion, and into areas of great moral dubiety, Schuklenk et al[134] note that

> "Measures are taken, and watchdog institutions are put in place to guard against abuse. Under-discussed but crucial functions within liberal democracies such as auditors general and ombudsmen are just two such offices. There is no reason to think that this could not also be done in the case of assisted death."

All legislation is subject to amendment. Safeguards are put in place by legislation, often in part based on proven experience gained by other jurisdictions who have already introduced similar laws, including those related to assisted dying. Other safeguards can be instituted in response to

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[133] Schuklenk et al (2011) *End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making. Bioethics ISSN 0269-9702 (print); 1467-8519 (online) Volume 25 Number S1 2011:48* https://pmc.ncbi.nlm.nih.gov/articles/PMC3265521/

[134] ibid:49

potential issues that have been highlighted within the debate related to legislation, and those safeguards will be the law.

The only change in AD in Scotland can be a change in the law. There can only be change if it is the settled will of the people and of the Scottish Parliament to do so.

Oregon is a reasonable comparator with Scotland in terms of population size. In 2024, Oregon's population is estimated to be around 4.27 million. At the most recent count, Scotland's population was 5,463,300. It can be noted that there has been no evidence of the slippery slope predicted by opponents when AD was introduced in Oregon. As Beauchamp & Childress note:

> "To date none of the abuses some predicted have materialized in Oregon.The Oregon statute's restrictions have been neither loosened nor broadened. There is no evidence that any patient has died other than in accordance with his or her own wishes. The number of patients seeking prescriptions under the statute has been low and stable (at around sixty per year), and hastened death has not been used primarily by individuals who might be thought vulnerable to intimidation or abuse. Those choosing assisted death have had, on average, a higher level of education and better medical coverage than terminally ill Oregonians who did not seek assistance in dying. Women, people with disabilities, and members of disadvantaged racial minorities have not sought assistance in dying in disproportionate numbers. The overwhelming number of persons requesting assistance in dying are caucasian, and the gender of the requesters reflects the general population. Meanwhile, reports indicate the quality of palliative care has improved in Oregon. About one-third of the patients requesting assistance in dying ultimately decide not to use the prescribed drug."[135]

Deliens[136], with reference to Wels and Hamarat[137], found:

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[135] Beauchamp, TL & Childress, JF. The Principles of Biomedical Ethics, 7th Ed. Oxford University Press (2013): p181

[136] Deliens L. Assisted Dying and the Slippery Slope Argument—No Empirical Evidence. *JAMA Netw Open*. 2025;8(4):e256849. doi:10.1001/jamanetworkopen.2025.6849 https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2833184

[137] Wels J, Hamarat N. Incidence and prevalence of reported euthanasia cases in Belgium, 2002 to 2023. *JAMA Netw Open*. 2025;8(4):e256841. doi:10.1001/jamanetworkopen.2025.6841 ArticleGoogle Scholar

> "Research evidence from Belgium does not support the repeatedly expressed concern that older people, disabled people, or people with psychiatric disorders would be under pressure to access euthanasia. On the contrary, evidence demonstrates that requests for euthanasia from persons 80 years or older are granted less often and withdrawn more often. The chances of accessing euthanasia were found to be also lower when depression was one of the reasons for seeking euthanasia."

Jackson Pickett[138] note that:

> "In both the Netherlands and Oregon, vulnerable groups are less likely to select euthanasia or assisted suicide. The mentally handicapped, psychiatric patients, and children are underrepresented among patients selecting euthanasia or assisted suicide in the Netherlands."

Professor Emeritus Jocelyn Downie, in her review of the Supreme Court of Canada's ruling records that the Supreme Court confirmed that there is:

> "no evidence from permissive regimes that people with disabilities are at heightened risk of accessing physician-assisted dying; no evidence of inordinate impact on socially vulnerable populations in permissive jurisdictions; in some cases palliative care actually improved post-legalisation; physicians were better able to provide overall end-of-life treatment once assisted death legalised; the trial judge, after an exhaustive review of the evidence, rejected the argument that adoption of a regulatory regime would initiate a descent down a slippery slope into homicide."[139]

Nonetheless, as Dankwort[140] notes:

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[138] Jackson Pickett "Can Legalization Improve End of- Life Care? An Empirical Analysis of the Results of the Legalization of Euthanasia and Physician-Assisted Suicide in the Netherlands and Oregon https://publish.illinois.edu/elderlawjournal/files/2015/02/Pickett.pdf

[139] Downie, Joyce (2016) *Permitting Voluntary Euthanasia and Assisted Suicide: Law Permitting Voluntary Euthanasia and Assisted Suicide: Law Reform Pathways for Common Law Jurisdictions Reform Pathways for Common Law Jurisdictions*. QUT Law Review Volume 16, Issue 1: 97 https://digitalcommons.schulichlaw.dal.ca/cgi/viewcontent.cgi?article=1906&context=scholarly_works

[140] Dankwort, Juergen. (2024). Voluntary Assisted Dying: The Impasse and a Way Forward. Canadian Journal of Bioethics / Revue canadienne de bioéthique, 7(4), 64–70. https://doi.org/10.7202/1114959ar

> "criticism about MAID gained traction even when only based on inconclusive evidence citing grey literature, often with identical sensationalized narrative accounts in the media".

Existing assisted dying laws vary. A number of states include access for those with a medically futile condition that causes unbearable suffering and who are simply experiencing a slower traumatic death - people with degenerative and chronic illnesses such as Motor Neurone Disease, Multiple Sclerosis, Parkinsons and Chronic Rheumatoid Arthritis. Others limit the choice to the terminally ill expected to die within a limited period of time. In both cases, extensive research and debate in those states led to the conclusion that the slippery slope simply has not manifested.

Critics of AD cite the growth in numbers of people resorting to AD after its introduction in various countries. This fails to take into account the numbers who would have previously sought to end their lives in isolation, and the numbers who otherwise would have died anyway, possibly in pain, possibly through self-starvation and dehydration or possibly via heavy dosage overdose, for example. As Schuklenk[141] observes:

> "If more people avail themselves of assisted dying over time, that should reasonably be seen as an indication of a service that is increasingly utilized by the populations it is intended to serve. That is not in its own right evidence of a problematic slippery slope."

The overwhelming majority of people who make use of the access provided by these laws have cancer. It should also be noted that many sufferers who choose to make themselves eligible for assisted dying choose not to go through with it, but are simply happy to have peace of mind that the choice is there for them if needed.

Oregon psychiatrist David Pollack, M.D. notes that:

> "I think there is enough accumulated experience in the states and other jurisdictions in which the practice of PAD is legally permitted to establish that the 'slippery slope' has not emerged nor does it appear to be emerging….The safeguards in the legislation or regulations in these jurisdictions have proven to be adequate to prevent an ever-growing

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[141] Schuklenk, Udo. Assisted Dying in Canada, Healthcare Papers Vol. 14 No. 1 42 https://www.academia.edu/9188749/Assisted_Dying_in_Canada?email_work_card=view-paper

> approval of requests for PAD for inappropriate or excluded reasons/ criteria."[142]

As Justice Baudouin in Canada concluded after considering expert evidence:

> "Neither the national data in Canada or Quebec nor the foreign data indicate any abuse, slippery slope or even heightened risks for vulnerable people when imminent end of life is not an eligibility criterion for medical assistance in dying."[143]

4.2 Bracket creep?

Opponents of assisted dying sometimes refer to Belgium as an example of 'bracket creep"[144], where eligibility for assisted dying has expanded. The inference is that changes of scope of activity and in the law are arbitrary and without a legal basis. An example cited by opponents of AD in Belgium, in very narrow circumstances, is that a child (and the child's parents) can request assistance to die. The question here is however a simple one - are you more compassionately protecting the child who is suffering horrifically and without sufficient relief by denying or by allowing access to an assisted death? The Belgian legislation provides for a child in a 'medically futile condition', and who is experiencing constant and unbearable suffering that cannot be alleviated, to request voluntary assisted dying. However, this law carries even greater safeguards, and stricter criteria, than the already strict laws relating to adults. "The relevance of age was regarded as less important than the capacity for discernment of involved issues and implications"[145], and must be assessed and confirmed by a multidisciplinary team including a clinical child psychologist and at least two doctors. The child's parents must also participate in, and approve of, the request. Passed into law by a two-thirds majority of the Belgian parliament, this is a recognition that even children can die from illnesses which, in spite of the best treatment, cause horrific suffering. Use of this provision in Belgium is extremely rare.

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[142] Moran, Mark (2019) *How Should Organized Medicine Respond to Physician-Assisted Death?* Psychiatrics News, Volume 54, Number 3 https://psychiatryonline.org/doi/full/10.1176/appi.pn.2019.1b23

[143] Downie, Jocelyn & Schuklenk, Udo (2021) *Social determinants of health and slippery slopes in assisted dying debates: lessons from Canada. Journal of Medical Ethics, Volume 47, Issue 10: 667* https://jme.bmj.com/content/47/10/662

[144] https://www.academia.edu/49721225/Euthanasia_and_assisted_suicide_good_or_bad_public_policy?email_work_card=view-paper

[145] Radbruch et al (2016) *Euthanasia and physician-assisted suicide: A white paper from the European Association for Palliative Care*. Palliative Medicine Volume 30, Issue 2: 107 https://journals.sagepub.com/doi/epub/10.1177/0269216315616524

Contrary to the inference of opponents, this development did not occur casually or as a surreptitious 'creep' or 'slippery slope', but in fact through a process of extensive consultation and public and political debate and in this case a two-thirds majority in Parliament. No change would have occurred without public support and the assent of Parliament. As Schuklenk[146] confirms:

> "The bill in Catholic Belgium had overwhelming public and parliamentary support (BBC 2014). Extensive public consultations were held and opponents of the bill had their say. Their arguments lost. The vote mirrored societal trust in an assisted dying regime that built up over the years and is pretty much unwavering, despite concerted efforts on the part of religious groups."

In the decades that assisted dying has operated elsewhere, there remains a lack of verified proof in relation to predictions of enforced killing of the unwilling sick, disabled, aged or vulnerable.

Where the recording and reporting process linked to assisted dying has identified anomalies and possibly problematic outliers to be investigated, as recently has been reported in Canada, this is not evidence of failure or a slippery slope, as claimed by opponents, but proof that the reporting systems put in place are working.

4.3 Changes in law

As the Church of Scotland, longtime opponents of AD acknowledge:

> "as yet there are no examples from the international community where a jurisdiction has expanded eligibility criteria where it was initially restricted to terminal illness…. this would have to be done through the legislative process".[147]

Laws are in some cases adapted and changed over time. The evolution of any law only occurs where facts, shared morality, democratic consensus, and public, judicial and Parliamentary assent will allow.

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[146] Schuklenk, Udo. Assisted Dying in Canada, Healthcare Papers Vol. 14 No. 1 42 https://www.academia.edu/9188749/Assisted_Dying_in_Canada?email_work_card=view-paper

[147] Church of Scotland. Joint Report of the Theological Forum and the Faith Action Programme Leadership Team on Assisted Dying. 2025 https://www.churchofscotland.org.uk/__data/assets/pdf_file/0004/133645/Volume-of-Reports-2025.pdf

5) 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[148] 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

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

general “such deaths are not even usually recorded as suicides”.[149] [150] 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[151], and reconfirmed by the Ross ruling by the Scottish Court of Session in 2016[152], 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[153]. 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[154], 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

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[149] 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

[150] 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.

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

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

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

[154] 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."[155]

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."[156]

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."[157]

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."[158]

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.

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[155] 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/

[156] 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

[157] 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

[158] 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".[159]

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[160] 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:

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[159] 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

[160] 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[161] 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."[162]

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.

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[161] 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.

[162] 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."[163]

In another study, Downar et al state:[164]

> "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.

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[163] 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/

[164] 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[165] 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[166]. 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."[167]

Slorach[168] 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.

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

[166] 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.

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

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

Loewy[169] 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[170] [171]. 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.[172] 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.

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

[170] 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."

[171] 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

[172] 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

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

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.

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

A Canadian case, cited by AD opponents is that of Rose Finlay[173] [174] 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'[175], 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:

> "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."[176]

As part of the campaign of opposition to assisted dying, opponents' claims have been used to amplify concerns of some disabled and chronically ill

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[173] 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

[174] 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

[175] 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

[176] 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

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[177] 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.[178] 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[179] 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.

According to a 2013 Yougov poll[180] 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.

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[177] 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

[178] 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-ID85E62UXHMijsiNfCldvAjFm4mu-yzWoE6M30A_aem_q0wZ3VTNyF17cvPtG-HU-A

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

[180] 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

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[181].

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."[182]

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"[183] 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[184] in Scotland found that 79% of disabled people support legalising assisted dying.

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

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[181] 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

[182] 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

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

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

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.

7) Is Assisted Dying in opposition to religious and moral values?

In Scotland no religious group can enforce their views upon a general population which includes non-believers. Religious individuals can continue to live according to religious doctrine even if the law of the nation is contrary. For example a Christian can choose not to work on the sabbath, even if others do. Similarly, that individual can choose not to avail themselves of a right to choose an assisted death, even if others do. They can however also choose to do so.

Loewy[185] notes:

> "An argument about an ethical question can be settled by "authority" only within an enclave of persons who accept the same "authority" without further question—a religious community that determines "right" and "wrong" as derived from a book or from the head of such an organization may be an example. To believers, such a "proof" will be convincing; to the non-believer it will be irrelevant."

Influential religious organisations continue to oppose assisted dying. However, in strong contrast a majority of lay members support the introduction of Assisted Dying. A 2019 Populus poll found that 80% of religious people – and 84% of the general public – supported a change in the law to allow assisted dying.[186]

7.1 Opposition by religious bodies

Kettell[187] notes that:

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

[186] Sherwood, Harriet (2023) *Religious leaders 'out of step with flocks' on assisted dying, says UK rabbi.* Guardian. https://www.theguardian.com/society/2023/jul/03/religious-leaders-out-of-step-with-flocks-on-assisted-dying-says-uk-rabbi-jonathan-romain

[187] Steven Kettell. How, When and Why Do Religious Actors Use Public Reason?The Case of Assisted Dying in Britain. Politics and Religion , Volume 12 , Issue 2 , June 2019 , pp. 385 - 408 DOI: https://doi.org/10.1017/S175504831800086X
https://wrap.warwick.ac.uk/id/eprint/112166/1/WRAP-how-when-why-religious-assisted-dying-Kettell-2018.pdf

> "Strong links exist between higher levels of religiosity and more conservative attitudes towards assisted dying, indicating that religious opposition is driven by theological concerns".

Some religious leaders argue for the sanctity of life insofar as it is not the right of men or women to take a life. Suicide is regarded as a sin by a number of religious organisations. The concept of purification through suffering, pain as karma or God's will, and suffering as a test of faith is found within a number of the most influential religions, including Christianity, Islam, Hinduism and Buddhism. Those who oppose assisted dying argue that they feel it is "playing god" or against God's will. Under that logic, every medical intervention to help somebody, from anaesthesia to blood-transfusions to heart-transplants and beyond, could be seen to be against God's will. A common refrain from supporters of AD is that we don't force animals to die as badly as those we purport to care for, but as Kanellopoulou notes:

> "In the Judaeo-Christian tradition human life is of special significance because God has set humans apart from other created beings in virtue of establishing the possibility of a personal relationship with them. The contention that human beings are their souls became a widely held Christian belief as a result of the influence of the Hellenistic thought. The Catholic Church holds that "ensoulment" is the basis for personhood but the justification it offers is not a philosophical but a moral one."

However Kettell's research indicates that there has been a clear strategic shift by larger religious organisations to couch their opposition around non-religious arguments, a 'strategic secularism' in order to promote an underlying religious agenda.

Most religious bodies give strong prominence to non-religious debate-points when making their arguments against assisted deaths[188]. In England Justin Welby, the Archbishop of Canterbury, before he resigned, argued instead for "properly fund and resource palliative care, community support services and mental health provision"[189], and that "it does not serve dignity if in granting the

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[188] Steven Kettell. How, When, and Why Do Religious Actors Use Public Reason? The Case of Assisted Dying in Britain. Politics and Religion , Volume 12 , Issue 2 , June 2019 , pp. 385 - 408
DOI: https://doi.org/10.1017/S175504831800086X

[189] https://www.archbishopofcanterbury.org/about/meet-justin-welby/archbishop-justins-priorities/archbishop-canterbury-warns-against

wishes of one closest to me I devalue the status and safety of others."[190] He has argued that those who suffer neglect or abuse, along with the severely disabled may feel driven toward an assisted death. In the Daily Mail he wrote

> "The right to end your life could all too easily – all too accidentally – turn into a duty to do so."[191]

In 2005, the Chief Rabbi's Office quoted a Jewish law expert Rabbi JD Bleich[192] in evidence to a Westminster parliamentary select committee:

> "Any positive act designed to hasten the death of the patient is equated with murder in Jewish law, even if the death is hastened only by a matter of moments…No matter how laudable the intentions of the person performing an act of mercy-killing may be, his deed constitutes an act of homicide."

Although the phrase 'qatalur-rahmah' or mercy-killing exists within Islamic culture and texts, the concept remains opposed by Islamic organisations. The British Board of Imams & Scholars (BBSI) cites[193] a variety of quotations from the Qur'an indicating for the sanctity of life and against the taking of one's own life. Their position is that suicide and euthanasia are forbidden by Allah:

> "Islam is unequivocal in its prohibition on suicide, and assisted dying. The BBSI holds strongly to this position. We underscore Islam's deep care and consideration for those who suffer from illnesses. This compassion does not grant us the right to end the great gift of life."

The BBSI argues that all that happens is the will of Allah:

> "Allah does not burden a soul beyond that it can bear."

Dr Musharraf Hussain expands upon this point:

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[190] https://www.archbishopofcanterbury.org/speaking-writing/speeches/archbishop-justin-speaks-assisted-dying-bill-house-lords

[191] "The right to end your life could all too easily – all too accidentally – turn into a duty to do so."

[192] Jewish Chronicle November 7, 2024. https://www.thejc.com/news/uk/what-does-judaism-say-about-the-assisted-dying-bill-surprisingly-rabbis-argue-t87z7z8u

[193] https://bbsi.org.uk/portfolio/assisted-dying-bill/#:~:text=Islam is unequivocal in its,the great gift of life.

> "Suffering as a test and submission to Divine Will: Suffering in Islam has spiritual significance, serving as a test of faith and character."[194]

As far back as 1994, the General Assembly of the Church of Scotland agreed that:

> "..the General Assembly opposes the introduction of legislation on Euthanasia, abhors its practice, and rejects the principles on which it is proposed"[195]

In a detailed 2009 review of end-of-life options, the Church of Scotland states:

> "The command from God which says 'you must not kill' is usually interpreted as meaning 'you must not murder'. However, a broader interpretation is that you must not take human life. This rules out euthanasia (and assisted suicide), as carrying these out would be against God's commandments, and would be an attack on the sovereignty of God."[196]

The Church of Scotland however recognised that:

> "However, for those with different, or indeed no religious beliefs, many would claim the right to exercise autonomy in taking this final decision."[197]

In Scotland, the Church of Scotland, Roman Catholic Church, and the Scottish Association of Mosques have opposed assisted dying and euthanasia.[198] In May 2023, Bishop John Keenan, the Rt Rev Iain Greenshields, and Imam Shaykh Hamza Khandwalla, Imam of Dundee Central Mosque signed a statement[199] urging MSPs to vote down Liam McArthur's proposal.

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[194] https://www.musharrafhussain.com/the-muslim-perspective-on-the-assisted-dying-bill/

[195] https://www.churchofscotland.org.uk/__data/assets/pdf_file/0007/3877/end_of_life_ga09.pdf

[196] Church of Scotland: Church and Society Council. End of Life Issues, 2009. https://www.churchofscotland.org.uk/__data/assets/pdf_file/0007/3877/end_of_life_ga09.pdf

[197] ibid

[198] https://rcpolitics.org/scottish-faith-leaders-speak-out-against-assisted-suicide/

[199] https://democratonline.net/2023/05/18/religion-scottish-faith-leaders-speak-out-against-assisted-suicide/

The Roman Catholic Church in Scotland remains opposed to assisted dying. In 2024, Scottish Bishops urged Catholics to reject the 'dangerous' assisted dying proposal.[200] Bishop John Keenan stated:

> "Assisted suicide sends a message that there are situations when suicide is an appropriate response to one's individual circumstances, worries, anxieties. It normalises suicide and accepts that some people are beyond hope."

After a 2024 consultation, the Church of Scotland reiterated concerns on issues such as capacity, vulnerability, coercion, and the possibility of the law broadening the scope of eligibility in the future. The response noted:

> "The Church is "partially opposed" to the legislation becoming law due to its historic opposition to assisted dying while recognising that this position is currently under review following debates and decisions made by the General Assembly in 2023 and 2024."[201]

A joint statement in 2023 from Rev Dr Iain MacLeod Greenshields, Moderator of the General Assembly of the Church of Scotland, and Rev Bishop John Keenan, Bishop of Paisley, reiterated that the churches:

> "do not believe that this is the correct approach to the alleviation of suffering.…The ways in which similar laws in other countries are being applied, and the effect that its introduction would have some of the most vulnerable in our society, including older people and people with disabilities, would be extremely detrimental. Society is called to care for those who are suffering, not to end their lives…. The Church of Scotland and the Roman Catholic Church in Scotland remain firm in their opposition to assisted suicide and euthanasia."[202]

The 2025 Church of Scotland General Assembly received a Joint Report of the Theological Forum and the Faith Action Programme Leadership Team on Assisted Dying. The Report[203] noted that:

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[200] https://scmo.org/news-releases/perma/1714032000/article/bishops-urge-catholics-to-reject-dangerous-assiste.html

[201] https://www.churchofscotland.org.uk/__data/assets/pdf_file/0005/125978/2024.08.16-Assisted-Dying-for-Terminally-Ill-Adults-Scotland-Bill-Stage-1-Call-for-Evidence.pdf

[202] https://www.scottishlegal.com/articles/churches-oppose-scottish-bill-on-assisted-dying

[203] Church of Scotland. Joint Report of the Theological Forum and the Faith Action Programme Leadership Team on Assisted Dying. 2025. https://www.churchofscotland.org.uk/__data/assets/pdf_file/0004/133645/Volume-of-Reports-2025.pdf

> "The Church of Scotland had been consistent in its opposition to assisted dying and euthanasia for decades….However, a countermotion recognising opinion in the Church was more diverse than outright opposition was moved. This countermotion also instructed that this diversity of views be explored further. On a vote, 103 voted for the original motion to reaffirm the Church's blanket opposition to assisted dying, while 225 voted for the countermotion, which then passed 238–71, with five commissioners recording dissent."

The subsequent report cites a number of examples of self-killing in both Christian and Jewish religious texts that pass without criticism:

> "The closest biblical example to assisted dying, that of Saul asking his armour bearer to deliver the coup de grace, falls under the criterion of avoiding capture on the battlefield. Other criteria include when one's death is demanded by the authorities or by the gods, to restore honour, to avoid shame, or to end intolerable suffering…..Indeed, a number of Christians recognised as martyrs die at their own hand."[204]

In relation to the sovereignty of God, the Report notes:

> "Job says in acknowledgment of God's sovereignty, "A person's days are determined; you have decreed the number of his months and have set limits he cannot exceed" (Job 14:5). Ecclesiastes 8:8 speaks in similar terms: "As no one has power over the wind to contain it, so no one has power over the time of their death" (see also Psalm 139.6). Some would interpret these texts to mean that God's sovereign rule implies that any intervention to shorten one's life is an assault upon that sovereignty. In this view, only circumstances can legitimately shorten life, not human intervention. Others would argue these are descriptive of the limits of human understanding in an ancient context, and to take them as prescriptive for contemporary ethics is merely proof-texting. Moreover, taken literally, texts such as these could be used to rule out medical intervention….medical interventions such as vaccines, surgery, and pharmacology already influence the length of our lives. We have the right to withhold or withdraw a life sustaining treatment, which will hasten an inevitable end, or to refuse a treatment such as resuscitation,

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[204] Church of Scotland. Joint Report of the Theological Forum and the Faith Action Programme Leadership Team on Assisted Dying. 2025. https://www.churchofscotland.org.uk/__data/assets/pdf_file/0004/133645/Volume-of-Reports-2025.pdf

but these are not viewed as controversial or a denial of God's sovereignty."[205]

In the conclusion to the Joint Report of the Theological Forum and the Faith Action Programme Leadership Team on Assisted Dying acknowledges that:

> "the range of views in the Church explored above may lead to three broad positions:
>
> - People who would continue to support the historic opposition to assisted dying.
>
> - People who would not choose assisted dying for themselves for theological or other reasons, but would support a change in the law as they recognise the ethical legitimacy of that choice for others.
>
> - People who would support a change in the law and would be at peace in their Christian faith to consider and/or choose assisted dying if they received a qualifying terminal diagnosis.
>
> Having explored the theological and ethical reasoning behind this spectrum of belief, we conclude that they can all be held with theological integrity within the Church of Scotland."[206]

The subsequent General Assembly vote however determined that the Church of Scotland would formally retain opposition to assisted dying.

7.2 Differing opinions of religious observers

As Jackson[207] observes:

> "God's monopoly on determining the moment of death has already been substantially usurped by modern medicine."

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[205] Church of Scotland. Joint Report of the Theological Forum and the Faith Action Programme Leadership Team on Assisted Dying. 2025. https://www.churchofscotland.org.uk/__data/assets/pdf_file/0004/133645/Volume-of-Reports-2025.pdf

[206] Church of Scotland. Joint Report of the Theological Forum and the Faith Action Programme Leadership Team on Assisted Dying. 2025. https://www.churchofscotland.org.uk/__data/assets/pdf_file/0004/133645/Volume-of-Reports-2025.pdf

[207] Jackson, Emily and Keown, John. Debating Euthanasia Hart, Oxford, 2012 (reprinted 2013 & 2014): 38

Other religious observers interpret their God's will differently in relation to the intractably suffering, and indeed interpretations of each religion differ. As Kenan Malik notes:

> "As social attitudes to slavery and witch-burnings transformed, so Christians came to interpret the Bible differently – which is another way of saying that they chose different values as making more sense within their religious perspective….Today, some Christians, reading passages in Leviticus and in Paul, think that the Bible justifies the execution of gay people. Others, reading the same Bible differently, celebrate the ordination of gay priests. Similarly with controversies from abortion rights to the treatment of asylum seekers. Each side reads the Bible as they wish to fit into their own moral framework. God is not the designer of that framework but comes to be its justification. And what is true of Christians is true also of Muslims, Jews, Hindus and believers in every other faith….Insisting that God mandates particular political and moral views, and so makes them unchallengeable, is equally to close off political debate and to ignore the variety of perspectives within any faith."[208]

Rabbi Dr Jonathan Romain has argued that:

> "it is possible to be both religious and in favour of assisted dying."[209]

As the Church of Scotland Joint Report of the Theological Forum and the Faith Action Programme Leadership Team on Assisted Dying [210] notes:

> "some theologians reject the notion that God wills anyone to suffer.[xxxiii] Hans Küng rejects as "religious rigorism without compassion" the view that intolerable suffering should be borne as an act of submission to God, as if that suffering has been inflicted by God. Instead, Küng argues, "for the terminally ill our theological task is not spiritualizing and mystification of suffering or even a pedagogical use of suffering ('purgatory on earth') but – in the footsteps of Jesus, who healed the sick – one of reducing and removing suffering as far as possible.""

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[208] https://www.theguardian.com/commentisfree/2024/dec/01/who-should-have-the-last-word-on-assisted-dying-in-a-secular-britain

[209] Watt, Nicholas (2014) *Former archbishop lends his support to campaign to legalise right to die.* Guardian. https://www.theguardian.com/society/2014/jul/12/archbishop-canterbury-carey-support-assisted-dying-proposal

[210] https://www.churchofscotland.org.uk/__data/assets/pdf_file/0004/133645/Volume-of-Reports-2025.pdf

Some who support assisted dying feel that those denying AD to others are not demonstrating their god's love and mercy, but that it is in fact cruelty masquerading as piety on purely religious dogmatic grounds. As Thomas Paine wrote, "belief of a cruel god makes a cruel man".[211] Any religious-based preference to deny the choice of AD to others and to impose suffering on others is by no means uncontroversial within current religious debate. As the Church of Scotland Joint Report of the Theological Forum and the Faith Action Programme Leadership Team on Assisted Dying[212] acknowledges:

> "The disagreement does not lie in the call to be compassionate, but rather how that compassion is lived out. This may mean that while we may personally recognise some value in end of life suffering, we may not wish to impose this theology on others, or in the words of Stanley Hauerwas, who nonetheless opposes assisted dying, "it is one thing for us to make our own suffering part of our life in service to God, it is quite another to make another's suffering part of his or her service to God."

Supporters of AD argue that helping a consenting person who is incurably suffering, for whom other remedies have failed, and who requests help in ending their life is analogous to acting as a good Samaritan who refuses to pass on the other side of the road in the moment of greatest need for the sufferer. In view of the work of the Samaritan service in the UK, this is an awkward analogy, but textually accurate. It can be argued that beneficence, and indeed non-maleficence can be seen to be achieved by ensuring greater harm, i.e. unnecessary suffering, is actively forestalled.

Governor Jerry Brown, a committed Catholic who had formerly trained as a Jesuit, wrote about signing Assisted Dying into law in a letter addressed to the California State Assembly:

> "In the end, I was left to reflect on what I would want in the face of my own death. I do not know what I would do if I were dying in prolonged and excruciating pain. I am certain, however, that it would be a comfort to be able to consider the options afforded by this bill. And I wouldn't deny that right to others."[213]

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[211] Paine, Thomas. The Age of Reason.

[212] https://www.churchofscotland.org.uk/__data/assets/pdf_file/0004/133645/Volume-of-Reports-2025.pdf

[213] McGreevy, Patrick (2015) *After struggling, Jerry Brown makes assisted suicide legal in California*. Los Angeles Times. https://www.latimes.com/local/political/la-me-pc-gov-brown-end-of-life-bill-20151005-story.html

Speaking to the Jewish Chronicle, former senior rabbi of West London Synagogue Baroness Neuberger said her rabbinical experience brought about a change of mind on the issue:

> "I had always been opposed to any form of assisted dying but I have changed my view in that in that I think given the way healthcare has gone, and given that we are ageing longer, I think there are times when individuals find their suffering unbearable."

Reverend Canon Rosie Harper has stated:

> "God surely does not insist on extreme suffering when there is a different, better way? There is no condemnation in the bible for someone who is too compassionate…by failing to support the change you personally are requiring other people to suffer extreme agony on behalf of your own conscience. That is neither moral or Christian."[214]

In a sermon Rev. Scott McKenna notes that:

> "We must move beyond the theology which says that God alone will choose the hour of death and what kind of suffering is to be endured and for how long. God gives us moral responsibility, the gift of choice, along with sense, reason and intellect. We are to use our gifts and leave behind a theology which portrays God as distant, brutal and unloving."[215]

Rabbi Jonathan Romain, the chair of Inter-Faith Leaders for Dignity in Dying and George Carey, former Archbishop of Canterbury state:

> "Some mainstream faith leaders might claim that this is contradicted by the verse from Job: "God gives and God takes" (1:21), and we cannot usurp that prerogative. Yet the God barrier has long been pushed aside both at the beginning and end of life, with humans acting in lieu of God, whether by doctors' efforts to create life using test tubes or to postpone death through heart transplants. If the religious ideal is to imitate God's ways, then it is our duty to use our God given abilities as much as possible. We could argue, therefore, that assisted dying is part of the constant act of playing God in the sense that God wants us to help

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[214] Harper, Rosie (2022) *Written evidence submitted by Revd Canon Rosie Harper* (ADY0066). UK Parliament. https://committees.parliament.uk/writtenevidence/114616/pdf/

[215] McKenna, Scott (2012) Reverend Scott McKenna Mayfield Salisbury Sermon 28-Oct-2012: 4. https://christiansforvad.org.au/wp-content/uploads/2014/08/Reverend_Scott_McKenna_Mayfield_Salisbury_Sermon_28-Oct-2012.pdf

> people in distress: to heal where possible, to comfort when needed, and to help let go of life when desired—this is what being religious means."[216]

The Religious Alliance for Dignity in Dying members represent major faith groups in the UK and numerous denominations: Church of England, Church of Scotland, Church of Wales, Church of Ireland, Catholicism, Baptism, Evangelism, Methodism, Unitarianism, United Reformed Church, Quakerism, Scottish Episcopal, Pentecostal, New Life Church, Jehovah's Witness and Mormon along with Liberal Judaism, Reform Judaism, Modern Orthodox, Masorti and United Synagogue, plus Ismamic, Hindu, Zoroastrian and pagan faith groups. They have made representations to the Westminster Parliament[217] in support of Assisted Dying. As Rabbi Dr Jonathan Romain states:

> "We can believe in the sanctity of life - how precious it is - but that does not mean believing in the sanctity of suffering, or disregarding steps to avoid it. There is nothing holy about agony."[218]

Rev Craig Kilgour notes:

> "You occasionally hear opponents to the Bill use the slippery slope argument, but this argument has been used for every social advance we have made in society: giving emancipation to people of colour, votes for women – we celebrate 125 years in New Zealand – decriminalizing homosexuality, same sex marriage. We are making society more permissive but more humane…."if God is love – and love is shown, yes God is present."[219]

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[216] Carey, G & Romain, J (2021) *There is nothing holy about agony: religious people and leaders support assisted dying too.* BMJ 2021; 374 doi: https://doi.org/10.1136/bmj.n2094 (Published 09 September 2021). BMJ 2021;374:n2094

[217] Religious Alliance for Dignity in Dying (2023) *Written evidence submitted by Religious Alliance for Dignity in Dying* (ADY0241) https://committees.parliament.uk/writtenevidence/116339/pdf/

[218] Romain, Jonathan (2023) *It's time to legalise assisted dying, in the name of compassion*. The Jewish Chronicle. https://www.thejc.com/lets-talk/its-time-to-legalise-assisted-dying-in-the-name-of-compassion-ulchmt7t

[219] Wood, Ian (2020) *Rev Craig Kilgour, New Zealand. Sermon – My nephew had an assisted death in Canada: it was compassionate, it was humane, it was right and good*. Christians Supporting Choice for Voluntary Assisted Dying. https://christiansforvad.org.au/rev-craig-kilgour-new-zealand-sermon-my-nephew-had-an-assisted-death-in-canada-it-was-compassionate-it-was-humane-it-was-right-and-good/#more-560

The Oxford Institute for British Islam states[220]

> "from the Qur'anic perspective - in contrast to the popular but fabricated ecclesiastical dogmas - there is no scriptural prohibition for devout Muslims enduring endless agony and inoperable suffering to terminate their lives if they so desire".

Dr Taj Hargey, Imam to the Oxford Islamic Congregation and Director of the Oxford Institute for British Islam, reflected that Qur'anic teachings on suffering and ending one's own life must be assessed in light of modern medical advances, which can often prolong the dying process. He asks:

> "when the quality of a person's life has deteriorated to such an extent and reached a point of no return in terms of endless pain and gratuitous anguish, should an empowered individual not have the right to depart this life?".[221]

Archbishop Desmond Tutu argued:

> "Dying people should have the right to choose how and when they leave Mother Earth. I believe that, alongside the wonderful palliative care that exists, their choices should include a dignified assisted death….In refusing dying people the right to die with dignity, we fail to demonstrate the compassion that lies at the heart of Christian values."[222]

Former Archbishop of Canterbury Lord Carey said:

> "The fact is that I have changed my mind. The old philosophical certainties have collapsed in the face of the reality of needless suffering."[223]

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[220] Oxford Institute for British Islam (2023) Written evidence submitted by Oxford Institute for British Islam (ADY0449). UK Parliament. https://committees.parliament.uk/writtenevidence/117055/pdf/

[221] https://www.dignityindying.org.uk/news/disability-rights-campaigner-palliative-care-doctor-rabbi-and-imam-speak-out-in-support-of-assisted-dying-law-as-lords-and-holyrood-prepare-to-debate-prospective-legislation/

[222] Tutu, Desmond (2016) *Archbishop Desmond Tutu: When my time comes, I want the option of an assisted death.* Washington Post. https://www.washingtonpost.com/opinions/global-opinions/archbishop-desmond-tutu-when-my-time-comes-i-want-the-option-of-an-assisted-death/2016/10/06/97c804f2-8a81-11e6-b24f-a7f89eb68887_story.html

[223] Carey, George (2014) *Assisted dying: Ex-Archbishop of Canterbury Lord Carey backs bill.* BBC News. https://www.bbc.co.uk/news/uk-28274531

Lord Carey further stated:

> "I would have paraded all the usual concerns about the risks of 'slippery slopes' and 'state-sponsored euthanasia'. But those arguments which persuaded me in the past seem to lack power and authority when confronted with the experiences of those approaching a painful death. It fails to address the fundamental question as to why we should force terminally ill patients to an unbearable point. It is the magnitude of suffering that has been preying on my mind as the discussion over the right to die has intensified."[224]

In a submission to MPs, Lord Carey said Assisted Dying was instead an

> "act of great generosity, kindness and human love to help those when it is the will of the only person that matters… It is profoundly Christian to do all we can to ensure nobody suffers against their wishes. Some people believe they will find meaning in their own suffering in their final months and weeks of life. I respect that, but it cannot be justified to expect others to share that belief."[225]

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[224] Watt, Nicholas (2014) *Former archbishop lends his support to campaign to legalise right to die.* Guardian. https://www.theguardian.com/society/2014/jul/12/archbishop-canterbury-carey-support-assisted-dying-proposal

[225] Carey, George (2023) *Written evidence submitted by Lord Carey George Carey* (ADY0293). https://committees.parliament.uk/writtenevidence/116625/pdf/

8) Is palliative care enough for every single case?

8.1 Definitions of palliative care and end of life

A general definition of palliative care is care and support received at any stage, from beginning to end of life, during a chronic or serious illness. It includes - but by definition is not limited to - end-of-life care. It can start from the point of diagnosis, and is specialised medical care that focuses on providing relief from pain and other symptoms. The World Health Organisation definition from 2002 is:

> "an approach that improves quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention of suffering by early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual."[226]

Section 257 of the Westminster Impact Assessment for AD[227] defines palliative care as:

> The care needed is often divided into two categories:
> 257.1. 'specialist care' delivered by professionals specifically trained in palliative and end-of-life care to support someone with complex symptom management in any setting.
> 257.2. 'non-specialist or universal care', delivered by health and social care professionals in any setting by, for example, district nurses or social carers, in primary care settings by GPs, and in secondary care settings by hospital staff.

The Leadership Alliance for the Care of Dying, a coalition of 21 national medical, palliative care and charitable organisations define 'end of life' as:

> "Patients are 'approaching the end of life' when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with:
> (a) advanced, progressive, incurable conditions
> (b)general frailty and co-existing conditions that mean they are expected to die within 12 months

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[226] Ashby, Michael (2016) *How We Die: A View from Palliative Care*. QUT Law Review Vol 16, Issue 1: p6. https://lr.law.qut.edu.au/article/view/619/581

[227] 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

(c) existing conditions if they are at risk of dying from a sudden acute crisis in their condition
(d)life-threatening acute conditions caused by sudden catastrophic events."[228]

8.2 Positions held on AD within palliative care representative organisations

Representative bodies for palliative care focus on respecting the views and wishes of the suffering individual, but AD remains contentious within a number of palliative care representative organisations. In general, palliative care organisations maintain a 'no decision about me without me' approach, one key exception being where a suffering patient requests an assisted death. They maintain that respect for individual autonomy cannot be an absolute value. A request for an assisted death can be viewed as a 'despairing cry' that can be argued to invalidate the legitimacy of the request and implying that counselling and drugs, when provided will suffice.

A common position remains that current palliative provision is sufficient. However it can be observed that the current anti-assisted dying orthodoxy is becoming increasingly vigorously debated and challenged within the palliative care community. The most positive supporters of assisted dying are unsurprisingly national palliative systems that have adopted assisted dying as a choice for their patients, and who arguably have been best able to test and allay the perennial concerns often expressed by opponents.

8.3 Current positions on AD of palliative care representative organisations

External to the UK

8.3.1 The International Association for Hospice and Palliative Care

A 2022 IAHPC Assisted Dying Practices and Euthanasia Survey[229] of members found:

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[228] https://assets.publishing.service.gov.uk/media/5a7e301ced915d74e33f09ee/One_chance_to_get_it_right.pdf

[229] IAHPC Assisted Dying Practices and Euthanasia Survey. 2022. https://iahpc.org/resources/publications/special-issues/assisted-dying-practices/methodology-and-key-findings/

- 49% support the availability of physician-assisted suicide. Of these, 56% think that it should be available only for specific situations (exceptional cases), with narrowly defined safety criteria.
- 47.5% support the availability of euthanasia. Of these, 55% think that it should be available only for specific situations (exceptional cases), with narrowly defined safety criteria.
- 45% stated that assisted dying or euthanasia should not be available at all.
- 5.7% and 7.6% were not sure about legalizing assisted dying or euthanasia, respectively.

8.3.2 The **European Association for Palliative Care (EAPC)** in their paper Euthanasia and physician-assisted suicide: a view from an EAPC Ethics Task Force[230], in 2003 argued that

> "None of the following should be seen as euthanasia within the definitions used here: withholding futile treatment; withdrawing futile treatment; `terminal sedation' (the use of sedative medication to relieve intolerable suffering in the last days of life)."

The most recent white paper[231] in 2016 recognises that there is a case to be made, and certainly a debate to be had, about assisted dying, whilst continuing for now with the status quo. They acknowledge that

> "complete consensus seems to be unachievable".

They acknowledge that a number of member states have introduced assisted dying support.

Finally the EAPC details the process of '*palliative sedation'*, which the EAPC sees as

> "acceptable, ethical practice"[232],

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[230] Palliative Medicine 2003; 17: 97 /101 Euthanasia and physician-assisted suicide: a view from an EAPC Ethics Task Force Lars Johan Materstvedt, David Clark, John Ellershaw, Reidun Førde, Anne-Marie Boeck Gravgaard, H Christof Muller-Busch, Josep Porta i Sales and Charles-Henri Rapin https://eapcnet.eu/eapc-publications/

[231] EAPC (2016) Euthanasia and physician-assisted suicide - *A white paper from the European Association for Palliative Care*. https://hospicecare.com/uploads/2019/3/Euthanasia and physician-assisted suicide- A white paper from the European Association for Palliative Care.pdf or https://view.pagetiger.com/ceniuje/1

[232] ibid

although the white paper notes that this had been the focus of much debate and also did not achieve consensus.

The white paper makes limited acknowledgement of the synergistic effect found in Belgium between existing palliative care and the introduction of assisted dying procedures as an additional choice for patients. It describes "integrative palliative care"[233] and the "growing involvement of palliative care professionals and teams in what they call 'the accompaniment of euthanasia"[234]. The white paper notes that

> "it is recognized that within Europe several approaches to euthanasia and physician assisted suicide (PAS) are emerging, and open and respectful debate surrounding this is to be encouraged…..The EAPC encourages its members to engage in direct and open dialogue with those who promote the legalization of euthanasia and PAS."[235]

Internal to the UK

https://www.palliativecarescotland.org.uk/news/news/sppc-submissions-to-parliament-on-the-assisted-dying-bill/

https://www.mariecurie.org.uk/document/assisted-dying-scotland-stage-one-responses-for-publication-2024

https://www.palliativecarescotland.org.uk/content/publications/SPPC-Response-to-Proposals-for-an-Assisted-Dying-Bill.pdf

8.3.3 The Association of Palliative Care Social Workers in their November 2024 Statement on Assisted Dying[236] take no position on AD, but summarise key arguments for and against and detail a range of recommendations should the legislation pass.

8.3.4 The Association for Palliative Medicine (of Great Britain and Ireland (APM)): a 2022 APM Scotland survey noted that "75% of Scottish APM members responding would not be willing to participate in any part of

[233] ibid

[234] ibid

[235] ibid

[236] Association of Palliative Care Social Workers. Statement on Assisted Dying, November 2024. https://apcsw.org.uk/wp-content/uploads/sp-client-document-manager/7/apcsw-full-statement-on-assisted-dying-november-20241.pdf

the assisted dying process and 98% stated that assisted dying should not be part of mainstream healthcare."[237]

8.3.5 Hospice UK strike a neutral tone of "no collective view", stating:

> "We believe that the assisted dying discussions must include how we can make good palliative care available and accessible to everyone, whoever they are and wherever they live."[238]

8.3.6 The Scottish Partnership for Palliative Care

In the Scottish Partnership for Palliative Care (SPPC) Response[239] to Proposals for an Assisted Dying for Terminally Ill Adults (Scotland) Bill, the organisation stated:

> "Assisted dying raises issues of a moral, personal and ethical nature upon which many of SPPC's member organisations (for example our member NHS Boards and some charities) are institutionally unable to hold a position. SPPC therefore does not adopt a position in principle either in support or in opposition to a change in the law.
>
> Instead, SPPC's approach is:-
> • To take a factual and evidential approach rather than a moral or religious one
> • To educate and inform about palliative and end of life care
> • To challenge misinformation about palliative and end of life care
> • To acknowledge and give an account of complexities which tend to get lost in polarised debates
> • To be honest about the limits of palliative care to relieve all suffering
> • To be honest about the current deficiencies in care towards the end of life experienced by some people"

The Partnership also noted that:

> "Most symptoms towards the end of life can be effectively managed most of the time."

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[237] https://apmonline.org/wp-content/uploads/APM-Position-Statement-on-Assisted-Dying-October-2024-v2.pdf 22/04/25

[238] https://www.hospiceuk.org/assisted-dying 22/04/25

[239] https://www.palliativecarescotland.org.uk/content/publications/SPPC-Response-to-Proposals-for-an-Assisted-Dying-Bill.pdf

They argue for better resources and resource management in Scotland. In relation to the practicalities of AD they express concerns over evaluation of capacity, slippery slope, coercion, level of knowledge of medical staff evaluating each request and to intervene if problems arise with ingestion of the lethal dosage, and staff welfare.

8.4 Responses to other palliative concerns

In addition to the common concerns (slippery slope, coercion of the vulnerable etc) expressed by opponents of AD, further concerns have been raised by representatives within the palliative care community and in relation to palliative care. For example, Mortier et al[240], while describing the introduction of AD as "a dangerous experiment" claim that their analysis of assisted death's in Belgium indicated that a significant percentage of patients receiving euthanasia did not see a palliative care specialist or a palliative care team or a psychiatrist. Their research does not detail in how many of these cases such support was available but refused, and in how many cases further treatment had been recognised as futile. In Scotland palliative care is available when needed and the Holyrood proposals include a review by a medical experts.

Hudson et al[241] raise a number of additional palliative concerns that can be briefly examined:

8.4.1 Where AD is legal, patients may fear the use of opioids is part of an unwanted and unmentioned AD process.

It is common practice in Scotland for skilled medical staff, and especially those involved in palliation, wherever possible to address any concerns and provide full and clear explanations and reassurances about any proposed treatment.

8.4.2 An over-medicalised death may remove the personal element, denying the patient a "broader spiritual, psychological, and social focus".

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[240] https://www.academia.edu/79518034/Between_Palliative_Care_and_Euthanasia?email_work_card=view-paper

[241] Hudson et al. Legalizing physician-assisted suicide and/or euthanasia: Pragmatic implications https://www.academia.edu/108813987/Legalizing_physician_assisted_suicide_and_or_euthanasia_Pragmatic_implications?email_work_card=view-paper

The Scottish proposals in no way preclude “broader spiritual, psychological, and social support”.

8.4.3 Without proper advisory support, the patient themselves may ‘misdiagnose’ their challenges, choosing AD over other options.

Again, skilled palliative staff should be able to address any such confusion and explain the alternative options available. AD is positioned as a final option, with all others palliative options explained and offered.

8.4.4 Assessing mental capacity can be problematic for doctors.

Specialists can be consulted, and training provided. Ensuring capacity is a key element of the Scottish proposals.

8.4.5 “Estimations of life expectancy are typically erroneous.” There may be outliers.

Predictions may not be accurate to the minute in many cases, but the judgement of experienced staff and clinical evidence available on the pace of progression generally tends to be fairly reliable.

8.4.6 Requiring opinions from other specialists ties up valuable time and resources. AD needs a multidisciplinary team response on the palliative team side rather than a single consultation which could be seen as tantamount to tokenism.

Current Scottish AD proposals provide for multi-disciplinary support. Multi-disciplinary support is already an integral part of the palliative care system.

8.4.7 Doctors may not have the additional counselling or “exquisite skills, judicious timing, and the capacity to engage in shared decision making” to participate in AD. A broad review and adaptation of current medical curricula would be required.

Specialists can be involved and consulted, as detailed in the Scottish proposals. Additional training, where required, can be provided.

8.4.8 The challenge of integrating AD into palliative provision may be overburdensome.

The process of integration appears to have taken place effectively elsewhere after AD has been introduced.

8.4.9 There may be risks that decisions for AD may be rushed, and either without understanding or trying palliative support at all, or of patients not having had equal access (due to differing regional provision or differences in insurance coverage), or the patient's understanding of the "failure" of palliative care may be based on experience of some available options, but not all possible other means of palliative support.

Insurance coverage is not a significant issue in Scotland. Palliative care in Scotland is recognised to be of a high quality. Skilled palliative staff already provide necessary explanations of available palliative options, and availability to all is significantly more universal than in systems elsewhere based around private insurance. All other palliative options will be available and explained to patients. AD would exist as a final option.

8.4.10 Some doctors and palliative care staff hold personal beliefs in opposition to AD, and conscientious objection should not be penalised.

No medical staff-member will be compelled to participate unwillingly. This is guaranteed within the Scottish Bill.

8.4.11 Why should doctors and palliative care staff be involved at all in administration, when the Swiss system allows volunteers and counsellors to administer, and in Oregon AD "need not be physician-assisted"?

Current Scottish proposals envision better regulation and support within a medical environment. In the Scottish proposals, a doctor may prescribe a fatal dose, but cannot legally administer it, although they will remain present. Worthington et al[242] raise the possibility of adverse effects of drugs used in AD, and as rare as this may be, if this occurs, medical support being immediately available would make sense. Cohen-Almagor[243] echoes the views of many that Physician Assisted Dying is more controlled, safer, better supervised and less open to abuse or mishap than simply leaving a patient to their own devices and a lethal pill:

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[242] Ana Worthington, Ilora Finlay, Claud Regnard. Efficacy and safety of drugs used for 'assisted dying'. Br Med Bull. 2022 May 4;142(1):15–22. doi: 10.1093/bmb/ldac009 https://pmc.ncbi.nlm.nih.gov/articles/PMC9270985/

[243] Cohen-Almagor, R. An argument for physician-assisted suicide and against euthanasia. https://www.academia.edu/20327902/An_Argument_for_Physician_Assisted_Suicide_and_Against_Euthanasia?email_work_card=view-paper

> "Physicians are best equipped in terms of knowledge and expertise to provide aid-in-dying."

As Deliens[244] notes:

> "Many of the professional skills and knowledge for quality palliative care are very similar to these that are needed for proper exploration and assessment of a euthanasia request. In Belgium after 20 years, there is no significant political or ideological or medical or palliative care opposition against euthanasia anymore; it has been embraced by society, by clinicians, and also by palliative care associations. Furthermore, a great many palliative care professionals are involved in the practice of euthanasia."

8.5 Responses to the argument that current palliative care is sufficient

Tragically there will still always be cases where current palliative care cannot improve the life of patients or sufficiently alleviate unbearable suffering. In studies such as 'Trends in Medical Aid in Dying in Oregon and Washington' where the reasons for choosing an assisted death are cited as lost autonomy, independence, and control[245], a closer look at the data confirms that:

> "Most patients who acquired lethal prescriptions had cancer or terminal illnesses that are difficult to palliate and lead to loss of autonomy, dignity, and quality of life."

In the Westminster Parliament Kim Leadbeater gave the example where Tom's family begged doctors to intervene, while

> "Tom vomited faecal matter for five hours before he ultimately inhaled the faeces and died. He was vomiting so violently that he could not be sedated, and was conscious throughout".[246]

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[244] Deliens, Luc. IAHPC. Vol 24, No4, April 2023. Belgium's 20-year history of assisted dying is well accepted by the public and health care practitioners; ideally, it should be integrated into palliative care. https://iahpc.org/resources/publications/special-issues/assisted-dying-practices/luc-deliens/

[245] Rabadi et al (2019) *Trends in Medical Aid in Dying in Oregon and Washington*. JAMA Netw Open. 2019;2(8):e198648. doi:10.1001/jamanetworkopen.2019.8648 https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2747692?utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_term=080919

[246] https://www.theguardian.com/commentisfree/2024/nov/29/assisted-dying-bill-life-death-mps

The report “The Inescapable Truth About Dying in Scotland”[247] provides compelling case-studies and evidence that palliative support as it currently legally operates is insufficient in a range of cases. In the report, “

> “the Office of Health Economics concludes that, even if every dying person in Scotland who needed it had access to the excellent level of care currently provided in hospices, 591 people a year would still have no effective relief of their pain in the final three months of their life. Evidence suggests that if people suffering from other unrelieved symptoms during the dying process were included this number would be much higher.”[248]

It can also be noted that where assisted dying has been available, in the end many who apply do not in the end take up that option - they are simply reassured that it would be available if and when other forms of palliative care are no longer enough. Feeling that they have taken back a degree of control of what remains of their life, and during a period where they can feel they have lost agency and dignity to intractable illness, is of no small benefit to patients.

Assisted dying as an additional final choice within palliative care is argued by supporters of AD as logical and compassionate. As Fantails et al[249] note:

> “Relief of suffering through an assisted death can be argued as a distinct entity to palliative care, with the former – if safely and carefully considered – potentially an important way of fulfilling a clinician’s duty to preserve autonomy and do good for a patient – for example, in cases where alternatives are treatments which provide no benefit or do not prolong or improve the quality of life of a terminally ill patient.”

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[247] https://features.dignityindying.org.uk/inescapable-truth-scotland/

[248] ibid

[249] Fantails et al (2018) *Euthanasia and assisted dying: what is the current position and what are the key arguments informing the debate?* Journal of the Royal Society of Medicine, Volume 111, Issue 11: Pages 407-413 https://journals.sagepub.com/doi/full/10.1177/0141076818803452

8.6 Current numbers

On average, 17 people a day in the UK experience painful deaths that cannot be relieved by the best palliative care[250].

According to the Office of Health Economics[251], in the UK there are

> "50,709 palliative care patients dying in some level of pain each year. Of these patients, 5,298 would still experience no pain relief at all in the last three months of life."

They reiterated the above to the Westminster Parliament:

> "there is recognition that the application of current best practice protocols for palliative care, such as the WHO's cancer pain ladder for adults or the NICE guidelines, cannot alleviate pain for all end-of-life patients…..Our estimate of 5,298 patients who would die without any pain relief at all represents an aspirational, best-case scenario where every patient receives the very highest standard of care as provided in hospices."[252]

Chris Whitty recently argued that

> "Modern medicine is amazing at keeping people alive and extending life … "but I think the question should be what do people want themselves".[253]

There is a point where the wonders of modern medicine turn from real relief to real trauma, keeping people alive while their incurable, intractable and excessive suffering continues. Supporters of AD argue that there are cases where palliative care currently available, however good, is not prolonging life, but instead prolonging a poor death.

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[250] Dignity In Dying: The Inescapable Truth About Dying in Scotland (2019): study commissioned by the campaign group Dignity in Dying and conducted by the Office of Health Economics, a research company. https://features.dignityindying.org.uk/inescapable-truth/

[251] Cookson et al (2019) *Unrelieved Pain in Palliative Care in England*. National Institute for Health Research. https://www.ohe.org/publications/unrelieved-pain-palliative-care-england

[252] https://committees.parliament.uk/writtenevidence/116982/pdf/

[253] Devlin, Hannah (2023) *Prioritise quality of life over prolonging it for elderly, Chris Whitty tells medics*. Guardian. https://www.theguardian.com/society/2023/nov/10/prioritise-quality-of-life-over-prolonging-it-for-elderly-chris-whitty-tells-medics

9 Is Assisted Dying incompatible with palliative care?

9.1 How palliative carers already participate in the death of patients in Scotland

We do not live in a state of "decreed compulsory living"[254]. There exists a range of methods and current ethical rules that enable the ending of a life within a medical context to be legally justified. Clarke & Egan[255] reiterate a common criticism of what many see as artificial distinctions between current practice and proposed AD practice:

> "Passive euthanasia is accepted and in reality is widely practised. It is often called withdrawal of therapy. If further care is unlikely to be of any therapeutic benefit, a physician is not obliged to continue therapy. The current approach is for a physician to declare that future therapy is futile and then to withdraw therapy on the basis of futility."

There are a good number of bioethicists, including Beauchamp and Childress themselves, who see little distinction between "killing" and "allowing to die"[256] [257] [258].

The attempt by opponents of AD within palliative care to differentiate medical involvement and assistance in current accepted practices in Scotland - such as of withholding treatment, withdrawing futile treatment, overdose by terminal sedation, or supporting a patient medically in dehydrating and starving themselves to death - from assisted dying is seen by critics of that position as splitting very fine hairs and at best a conceptual convenience. Indeed, Loewy[259] refers to the current common practice of Voluntary Stopping of Eating and Drinking as "physician stimulated starvation" and that

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[254] Dankwort, Juergen. (2024). Voluntary Assisted Dying: The Impasse and a Way Forward. Canadian Journal of Bioethics / Revue canadienne de bioéthique, 7(4), 64–70. https://doi.org/10.7202/1114959ar

[255] D L Clarke, A Egan. Euthanasia – is there a case? https://www.academia.edu/117086765/Euthanasia_is_there_a_case?email_work_card=view-paper

[256] White, Lucie. EUTHANASIA, ASSISTED SUICIDE AND THE PROFESSIONAL OBLIGATIONS OF PHYSICIANS. https://philpapers.org/archive/WHIEAS-2.pdf

[257] Beauchamp, T & Childress, J 1983, Principles of Biomedical Ethics (2nd ed.), Oxford University Press, Oxford.

[258] Brock, D 1992, Voluntary and active euthanasia, Hastings Center Report, vol. 22, no. 2, pp.10-22.

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

> "it should most certainly not be suggested to the patient as an alternative because the physician out of cowardice is unwilling to prescribe medication to accomplish the same end."

The argument in the end is whether there is significant difference ethically and under the law between a more direct causality approach i.e. supplying a pill, as compared to administering a drug to a patient over days until they weaken enough to die from an overdose or from dehydration and starvation or a mixture of both.

Palliative care already is already strongly regulated, and current proposals for assisted dying would introduce further strong and specific regulation. Downar et al note that there are:

> "parallels between media reports about the misuse of AD and reports of wrongful deaths due to the misuse of palliative care (PC) in jurisdictions where AD was not legal. Ultimately, we cannot justify having a different response to these reports when they apply to AD instead of PC, and nobody has argued that PC should be criminalized in response to such reports….We must remember that PC (palliative care) is no stranger to accusations of harm and wrongful death (especially among the vulnerable) in jurisdictions wherein AD is not legal. If we trust the oversight mechanisms that are used for accusations of malpractice or wrongful death in any jurisdiction, we should trust them in jurisdictions where AD is legal."[260]

9.2 VSED - the currently legal and acceptable way for a person to actively end their life with medical support

Jox et al[261] define VSED as the intention and act of causing the shortening and ending a life:

> "VSED is a form of suicide by omission – the person's omission of eating and drinking directly causes death."

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[260] Downar, MacDonald and Buchman (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. PMID: 37404196 https://pubmed.ncbi.nlm.nih.gov/37404196/

[261] Jox, Ralf J, Black, Isra orcid.org/0000-0001-5324-7988, Borasio, Gian Domenico et al. (1 more author) (2017) Voluntary stopping of eating and drinking: is medical support ethically justified? BMC Medicine. 186. ISSN 1741-7015 https://doi.org/10.1186/s12916-017-0950-1

According to Wechkin et al[262]:

> "VSED is a deliberate, self-initiated action by a patient with decision-making capacity (DMC) to hasten death in the setting of suffering refractory to optimal palliative interventions, prolonged dying that the person finds intolerable, or expected deterioration or suffering due to an irreversible illness, that the person regards as unacceptable. This action is typically undertaken by a patient with a serious illness associated with a life expectancy of months or years. VSED is characterized by the exercise of a specific choice at a specific time and is dependent on the patient having sufficient decisional capacity at the time that VSED is initiated."

9.2.1 Deep and continuous palliative sedation without artificial nutrition and hydration.

Most commonly, VSED in Scotland is supported by medical staff, and is carried out in conjunction with deep sedation. The patient is placed into an induced coma which continues until death. It is commonly argued that although the level of sedation is potentially lethal as the body weakens from starvation and dehydration, death is foreseeable but not intended (the doctrine of double-effect) by the provision and maintenance of the dosage. However as death is intended from the process as a whole, and in view of the lack of available research, the contribution of the dosage to overall cause of death remains open to debate.

9.2.2 Is VSED significantly different from AD?

A common argument is that medical involvement in Voluntary Stopping Eating and Drinking remains at 'arms-length', thereby removing any accusation of direct complicity and causality. Jox et al[263] note that:

> "Most Western jurisdictions seem to permit medical support for VSED, even in jurisdictions where assisted dying is prohibited by law.… the widely held position by palliative care societies, professional bodies of

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[262] https://www.jpsmjournal.com/article/S0885-3924(23)00565-1/fulltext

[263] Jox, Ralf J, Black, Isra orcid.org/0000-0001-5324-7988, Borasio, Gian Domenico et al. (1 more author) (2017) Voluntary stopping of eating and drinking: is medical support ethically justified? BMC Medicine. 186. ISSN 1741-7015 https://doi.org/10.1186/s12916-017-0950-1

> physicians, legal scholars, and ethicists to disapprove of assisted suicide but approve of and even promote medically supported VSED appears inconsistent".

Liu et al[264] contend that there are three types of 'Deep and Continuous Palliative Sedation without Artificial Nutrition and Hydration'. Type 1 is palliative sedation that will not hasten the patient's death. Type 2 might, but is not certain to, hasten death, as in the doctrine of double-effect. Type 3 is certain to hasten death. They note that all three types are practiced in Australia, Colombia, the Netherlands, Switzerland, the United States of America. The first two exist within palliative care provision in Scotland as, arguably, does the third.

Liu et al[265] note that Type 3 is perceived as a form of euthanasia in Australia, Colombia, the Netherlands, and Switzerland, and would be regarded as a form of AD in Ireland. Liu et al[266] acknowledge the risk that "there could be a situation where Type 3 Deep and Continuous Palliative Sedation without Artificial Nutrition and Hydration is allowed in the absence of the safeguards usually associated with euthanasia." Jox et al[267] are more forthright in arguing that:

> "VSED falls within the concept of suicide, albeit with certain unique features (non-invasiveness, initial reversibility, resemblance to the natural dying process). Second, we demonstrate, on the basis of

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[264] [264] Liu, Richard, Pope, Thaddeus Mason and and Xu, April, Deep and Continuous Palliative Sedation without Artificial Nutrition and Hydration: An International Review (September 14, 2024). 35 Indiana International & Comparative Law Review XXX (forthcoming 2025)., 35(1) Indiana International & Comparative Law Review 67-151 (2025), Available at SSRN: https://ssrn.com/abstract=4956660 or http://dx.doi.org/10.2139/ssrn.4956660 https://open.mitchellhamline.edu/cgi/viewcontent.cgi?article=1622&context=facsch 27/04/25

[265] Liu, Richard, Pope, Thaddeus Mason and and Xu, April, Deep and Continuous Palliative Sedation without Artificial Nutrition and Hydration: An International Review (September 14, 2024). 35 Indiana International & Comparative Law Review XXX (forthcoming 2025)., 35(1) Indiana International & Comparative Law Review 67-151 (2025), Available at SSRN: https://ssrn.com/abstract=4956660 or http://dx.doi.org/10.2139/ssrn.4956660 https://open.mitchellhamline.edu/cgi/viewcontent.cgi?article=1622&context=facsch 27/04/25

[266] Liu, Richard, Pope, Thaddeus Mason and and Xu, April, Deep and Continuous Palliative Sedation without Artificial Nutrition and Hydration: An International Review (September 14, 2024). 35 Indiana International & Comparative Law Review XXX (forthcoming 2025)., 35(1) Indiana International & Comparative Law Review 67-151 (2025), Available at SSRN: https://ssrn.com/abstract=4956660 or http://dx.doi.org/10.2139/ssrn.4956660 https://open.mitchellhamline.edu/cgi/viewcontent.cgi?article=1622&context=facsch 27/04/25

[267] Jox, Ralf J, Black, Isra orcid.org/0000-0001-5324-7988, Borasio, Gian Domenico et al. (1 more author) (2017) Voluntary stopping of eating and drinking: is medical support ethically justified? BMC Medicine. 186. ISSN 1741-7015 https://doi.org/10.1186/s12916-017-0950-1

> paradigmatic clinical cases, that medically supported VSED is, at least in some instances, tantamount to assisted suicide. This is especially the case if a patient's choice of VSED depends on the physician's assurance to provide medical support."

While the primary purpose of medical support in VSED may be symptom relief, as in AD the outcome is expected to be death. They go on to argue that:

> "Two elements of assistance in suicide are critical for our argumentation. First, the assistance is instrumental for death to occur, meaning that, without the assistance, the suicide would not (or could not) occur. Second, the assisting person knows and at least partially shares the patient's intention to induce death."[268]

VSED is practiced within Scottish palliative care as a best available option where a patient seeks to end their life. It is most commonly performed in conjunction with medical staff supporting the patient by inducing a coma and continuing to administer sedation, monitor the patient and provide care.

This is clearly the case, especially where VSED operates in conjunction with an induced coma.

9.2.3 Is VSED problematic?

In terms of public awareness, although euthanasia has a page on the NHS Scotland public website, there was still no mention anywhere relating to VSED or VRFF, in acronym or full-form on April 30 2025.

There is also an absence of published research specifically in relation to the support of VSED in palliative care in Scotland.

Some within palliative care suggest the practice of VSED remains relatively uncommon in the UK, while elsewhere research suggests a much more

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[268] Jox, Ralf J, Black, Isra orcid.org/0000-0001-5324-7988, Borasio, Gian Domenico et al. (1 more author) (2017) Voluntary stopping of eating and drinking: is medical support ethically justified? BMC Medicine. 186. ISSN 1741-7015 https://doi.org/10.1186/s12916-017-0950-1

common occurrence - Bolt et al[269] found in that in their survey of over 700 physicians between October 2011 and June 2012 in the Netherlands,

> "46% had cared for a patient who hastened death by VSED".

In their literature review, Mensger et al[270] found that

> "surveys from different countries have shown that 32%–62% of participating healthcare professionals had already accompanied a person during VSED".

The Scottish Partnership for Palliative Care note that:

> "there are no systematic mechanisms in place to measure and understand the experiences and outcomes of people dying in Scotland".[271]

While VSED has always been legal in Scotland, there is a definite lacuna in general in research into VSED. Lowers et al[272] found that:

> "Few studies have looked specifically at the incidence of VSED."

Pope et al[273] confirm that:

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[269] 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.

Christina Mensger, Yang Jiao, Maximiliane Jansky, Christian Banse, Friedemann Nauck, Monika Nothacker, Henrikje Stanze. Voluntarily stopping eating and drinking (VSED): A systematic mixed-methods review focusing on the carers' experiences. Health Policy Volume 150, December 2024, 105174. https://www.sciencedirect.com/science/article/pii/S0168851024001842 27/04/25

[271] https://www.palliativecarescotland.org.uk/content/publications/SPPC-Response-to-Proposals-for-an-Assisted-Dying-Bill.pdf

[272] Jane Lowers, Sean Hughes, Nancy J. Preston. Overview of voluntarily stopping eating and drinking to hasten death. Annals of Palliative Medicine, Vol 10, No 3 (March 31, 2021) https://apm.amegroups.org/article/view/44492/html 27/04/25

[273] Liu, Richard, Pope, Thaddeus Mason and and Xu, April, Deep and Continuous Palliative Sedation without Artificial Nutrition and Hydration: An International Review (September 14, 2024). 35 Indiana International & Comparative Law Review XXX (forthcoming 2025)., 35(1) Indiana International & Comparative Law Review 67-151 (2025), Available at SSRN: https://ssrn.com/abstract=4956660 or http://dx.doi.org/10.2139/ssrn.4956660 https://open.mitchellhamline.edu/cgi/viewcontent.cgi?article=1622&context=facsch 27/04/25

> "Deep and continuous palliative sedation combined with withholding or withdrawal of artificial nutrition and hydration….has gone largely unexamined".

General articles discussing VSED go back before 2000 - in 1993, Bernat et al[274] called for systematic research on VSED, but Mensger et al[275] in 2024 found available research dealt less with practice, and

> "mostly dealing with the ethical and legal issues",

and in their literature review Ivanović et al[276] note that

> "articles provide marginal insight into VSED for hastening death. Research is needed …. intensive examination of the literature shows that the subject under study has been marginally researched and that there is no scientific basis on which VSED could be explained in all of its dimensions".

The authors go on to describe existing research as a

> "continuous interweaving of published articles. In this respect, we conclude that the evidence was artificially reproduced over time through repeated citations of narrative reviews without new insights based on original studies."[277]

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[274] Bernat JL, Gert B, Mogielnicki RP. Patient refusal of hydration and nutrition. An alternative to physician-assisted suicide or voluntary active euthanasia. Arch Intern Med. 1993;153(24):2723–2728.

[275] Christina Mensger, Yang Jiao, Maximiliane Jansky, Christian Banse, Friedemann Nauck, Monika Nothacker, Henrikje Stanze. Voluntarily stopping eating and drinking (VSED): A systematic mixed-methods review focusing on the carers' experiences. Health Policy Volume 150, December 2024, 105174. https://www.sciencedirect.com/science/article/pii/S0168851024001842 27/04/25

[276] Ivanović, Nata & Bueche, Daniel & Fringer, André. (2014). Voluntary stopping of eating and drinking at the end of life - A 'systematic search and review' giving insight into an option of hastening death in capacitated adults at the end of life. BMC palliative care. 13. 1. 10.1186/1472-684X-13-1. http://www.biomedcentral.com/1472-684X/13/1 27/04/25

[277] Ivanović, Nata & Bueche, Daniel & Fringer, André. (2014). Voluntary stopping of eating and drinking at the end of life - A 'systematic search and review' giving insight into an option of hastening death in capacitated adults at the end of life. BMC palliative care. 13. 1. 10.1186/1472-684X-13-1. http://www.biomedcentral.com/1472-684X/13/1 27/04/25

9.2.4 Current providers of VSED cannot guarantee equality of provision

There are references to VSED in advisory documents by disparate medical organisations such as the GMC in 2015[278], the BMA in 2019[279] and the Royal College of Physicians in 2021[280]. Compassion in Dying, in their 2022 report Voluntarily stopping eating and drinking (VSED): A call for guidance[281] note:

> "The lack of guidance on VSED leads to significant inconsistencies in how it is managed by clinicians."

Liu et al[282] note:

> "[Deep and Continuous Palliative Sedation Without Artificial Nutrition and Hydration] is often not governed by a clear legal framework."

Dignity in Dying[283] argue that

> "Unlike other end-of-life practices, there are also no standardised guidelines in the UK for how healthcare professionals should support people who decide to hasten their death via VSED."

They note that inadequate pain relief can result from a lack of clear guidance.

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[278] General Medical Council, Patients seeking advice or information about assistance to die, June 2015, https://www.gmc-uk.org/-/media/documents/gmc-guidance—when-a-patient-seeks-advice-or-information-about-assistance-to-die_pdf-61449907.pdf

[279] British Medical Association, Responding to patient requests for assisted dying: guidance for doctors, June 2019, https://www.bma.org.uk/media/1424/bma-guidance-on-responding-to-patient-requests-for-assisted-dying-for-doctors.pdf

[280] Royal College of Physicians, Supporting people who have eating and drinking difficulties, March 2021, https://www.rcplondon.ac.uk/projects/outputs/supporting-people-who-have-eating-and-drinking-difficulties

[281] Compassion in Dying. Voluntarily stopping eating and drinking (VSED): A call for guidance. Nov 2022. https://cdn.compassionindying.org.uk/wp-content/uploads/vsed-call-for-guidance-november-2022.pdf

[282] Liu, Richard, Pope, Thaddeus Mason and and Xu, April, Deep and Continuous Palliative Sedation without Artificial Nutrition and Hydration: An International Review (September 14, 2024). 35 Indiana International & Comparative Law Review XXX (forthcoming 2025)., 35(1) Indiana International & Comparative Law Review 67-151 (2025), Available at SSRN: https://ssrn.com/abstract=4956660 or http://dx.doi.org/10.2139/ssrn.4956660 https://open.mitchellhamline.edu/cgi/viewcontent.cgi?article=1622&context=facsch 27/04/25

[283] Dignity In Dying: The Inescapable Truth About Dying in Scotland (2019): study commissioned by the campaign group Dignity in Dying and conducted by the Office of Health Economics, a research company. https://features.dignityindying.org.uk/inescapable-truth/

A Yougov survey in July 2022 commissioned by Compassion In Dying[284] of over 500 UK professionals found that

> "50% of the respondents did not have correct information about the legal status of VSED" and "94% of the respondents said it would be helpful for health and care professionals to have guidance on the legal and clinical aspects of VSED".

9.2.5 Known issues with VSED

Fringer and Staengle[285] describe VSED as

> "a critical but poorly understood issue".

Compassion in Dying[286] cite recent examples of patients experiencing difficulty in accessing information, being stonewalled, being referred to psychiatric services and in one case a patient requesting VSED being sectioned seven days before his death. They note:

> "People have also reported that their healthcare team refused to provide pain relief and symptom management when stopping eating and drinking."[287]

Without sufficient research it remains impossible to confirm that VSED deaths are as peaceful as some would claim, and there is anecdotal evidence to the contrary. Bolt et al[288] note that

> "the literature mostly comprises commentaries and case reports rather than original research…..They mention possible serious complications,

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[284] https://compassionindying.org.uk/resource/voluntarily-stopping-eating-and-drinking-vsed/#backlink-12 27/04/25

[285] Fringer, André and Stängle, Sabrina. Scientia, Nov 11, 2020 Editor's Pick, Medical & Health Sciences https://digitalcollection.zhaw.ch/server/api/core/bitstreams/0c46ed58-fe59-4e8c-a073-f5736cb68321/content 28/04/25

[286] https://compassionindying.org.uk/resource/voluntarily-stopping-eating-and-drinking-vsed/#what-people-tell-us-about-vsed 27/04/25

[287] Compassion in Dying. Voluntarily stopping eating and drinking (VSED): A call for guidance. Nov 2022. https://cdn.compassionindying.org.uk/wp-content/uploads/vsed-call-for-guidance-november-2022.pdf

[288] 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.

such as a prolonged dying phase, thirst or hunger, agitation, delirium, and overburdened family members".

Wax et[289] al state that

> "VSED is an intense process fraught with new sources of somatic and emotional suffering for individuals and their caregivers".

Jean Davis[290], while undergoing VSED without an induced coma, described the experience as:

> "It is hell. I can't tell you how hard it is. You wouldn't decide this unless you thought your life was going to be so bad. It is intolerable."

The Patients Rights Council[291] describes the process as follows:

> "As a person dies from dehydration, his or her mouth dries out and becomes caked or coated with thick material; lips become parched and cracked; the tongue swells and could crack; eyes recede back into their orbits; cheeks become hollow; lining of the nose might crack and cause the nose to bleed; skin begins to hang loose on the body and becomes dry and scaly; urine would become highly concentrated, leading to burning of the bladder; lining of the stomach dries out, likely causing the person to experience dry heaves and vomiting; body temperature can become very high; brain cells dry out, causing convulsions; respiratory tract also dries out causing thick secretions that could plug the lungs and cause death. At some point the person's major organs, including the lungs, heart, and brain give out and death occurs."

Proper palliative care can reduce the suffering of the patient as they starve and dehydrate. Wechkin[292] et al note that for those who remain awake experiencing VSED,

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[289] Wax JW, An AW, Kosier N, Quill TE. Voluntary Stopping Eating and Drinking. J Am Geriatr Soc. 2018 Mar;66(3):441-445. doi: 10.1111/jgs.15200. PMID: 29532465.

[290] Guardian. Sun 19 Oct 2014 14.19 BST https://www.theguardian.com/society/2014/oct/19/right-to-die-campaigner-starved-herself-jean-davies 28/04/25

[291] The Patients Rights Council. Voluntarily Stopping Eating & Drinking: Important Questions & Answers https://www.patientsrightscouncil.org/site/wp-content/uploads/2013/03/VSED_Questions.pdf 28/04/25

[292] Hope Wechkin, Robert Macauley, Paul T. Menzel, Peter L. Reagan, Nancy Simmers, Timothy E. Quill. Clinical Guidelines for Voluntarily Stopping Eating and Drinking (VSED). Journal of Pain and Symptom Management. Volume 66, Issue 5E625-E631November 2023 https://www.jpsmjournal.com/article/S0885-3924(23)00565-1/fulltext 27/04/25

> “end-of-life dreams and visions….may be eased with antipsychotic medications”,

However the Patients Rights Council cite a case where despite a patient being

> “administered small doses of morphine to combat cramps and a sedative to relieve ‘emotional anxiety’

but

> “after more than two weeks, she was “howling with anguish.””

It is also reasonable to note the same option to offer medication in response to visible suffering is not available to those in an induced coma whose peaceful stillness may belie a far from peaceful experience. While some may feel reassured by the apparent peace of their loved one in a comatose state, others can find it a more negative experience. The patient, although apparently comatose and inactive, may experience traumatic delirium, and possibly discomfort. At the same time, a traumatic deathwatch where days can extend into weeks is forced upon loved ones. There is also a sense of abandoning their loved one experienced by those who cannot stay 24 hours a day, due to the many other commitments they have. They may well be robbed of the catharsis from being with their loved one until and at the end.

A great deal has been taken on faith in the absence of research, in relation to VSED, simply because it has allowed the medical community to maintain a veneer of a passive role in the process.

Opponents of AD continue to argue that the implementation of AD within palliative care crosses a line in terms of direct involvement and causality in a willing patient’s end. However, there is now an ongoing and vigorous debate within palliative care organisations, and the previous opposition by other British medical representative organisations has been replaced by the adoption of a neutral stance to AD (see section 10).

In view of the successful adoption of AD within palliative care in various countries, it is reasonable to assume that at least a section of Scottish medical staff will be comfortable with the putative more active role required by AD.

In view of the lack of research supporting VSED despite its common implementation, an argument can be made that in avoiding a death-watch for loved ones and waking suffering or silent discomfort, and possible traumatic delirium, the brevity of the AD process may be both preferable and more compassionate.

Implementation of the McArthur Bill may also avoid a great deal of the ambiguity and poor understanding amongst not only the public but medical staff as to legal liability and acceptable practice in VSED.

9.3 Where AD has been integrated into palliative care

Where assisted dying has already been introduced (see map[293]), it has been possible to successfully integrate within palliative practice, as an additional and final choice available to patients.

In response to the EAPC White Paper, Chambaere et al[294] argue that

> "the White Paper ignores the extensive experience and substantial body of relevant empirical evidence in jurisdictions that have legalised euthanasia and/or physician-assisted suicide. Palliative care organisations within these jurisdictions have already had to react to legal assisted dying and thus provide prime 'case studies'. In these jurisdictions, professional palliative care is in fact involved in the vast majority of cases where requests have been made."

Bernheim et al"[295] examined "the effect of the process of legalisation of euthanasia on palliative care by reviewing published historical, regulatory, and epidemiological evidence in Belgium" and concluded:

> "we found few professional stances contending that palliative care and legalisation of euthanasia are antagonistic, no slippery slope effects, and no evidence for the concern of the European Association for Palliative Care that the drive to legalise euthanasia would interfere with the development of palliative care. Rather, there were many indications of reciprocity and synergistic evolution".

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[293] https://wfrtds.org/worldmap/

[294] Chambaere et al (2016) *The European Association for Palliative Care White Paper on euthanasia and physician-assisted suicide: Dodging responsibility*. Palliative Medicine Volume 30, Issue 9. https://doi.org/10.1177/0269216316664470

[295] Bernheim et al (2008) Development of palliative care and legalisation of euthanasia: Antagonism or synergy? BMJ. Apr 19;336(7649):864–867. https://pmc.ncbi.nlm.nih.gov/articles/PMC2323065/

10) Will introducing assisted dying reduce funding for palliative care and other areas of medicine?

An attempt to stifle debate within palliative care representative organisations on the issue of AD was observed by a number of contributors to the Second Report of Session 2023–24 of the House of Commons Committee report[296], but more recently voices supporting AD within the palliative care community have opened up the debate.

A common and key theme of opposition to AD within palliative care organisations is the fear of defunding of palliative care, and a possible loss of prestige, if assisted dying is introduced. This has not proven to be the case in states where assisted dying is now established. A key argument that opponents within palliative care put forward is that insufficient resources for palliative care is the key reason why problems exist in caring for those for whom currently available palliative support is simply insufficient. It is an argument that implies that medical science, if funded sufficiently will be a panacea for all conditions. Again, this is a choice to ignore the existence of conditions and levels of suffering and indignity for which there is simply no modern medical solution. It is understandable that palliative carers are protective of their budgets and very reluctant to see anything introduced that could potentially drain resources. However in states where assisted dying has been introduced, and this question has been researched, funding and resources have either remained consistent or actually increased.

A debate does indeed exist in general on the level of availability of quality care and sufficient places in care homes/palliative care facilities. There is an argument for seeking further improvements in the provision of palliative care, but this is not a justification for the denial of the additional choice of assisted dying being available to those who need it. Two things can be true - that it is in the interests of patients to see improvements in palliative care resourcing, and also in the interest of patients to have the additional choice of AD available, if they wish, as part of palliative care. As Downie and Schuklenk[297] note

> "As Justice Smith observed in Carter: "the argument that legalization should not be contemplated until palliative care is fully supported rests, as Dr. van Delden observed, on a form of hostage-taking."

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[296] https://publications.parliament.uk/pa/cm5804/cmselect/cmhealth/321/report.html#footnote-393-backlink

[297] Downie and Schuklenk (2021) *Social determinants of health and slippery slopes in assisted dying debates: lessons from Canada*. BMJ Journal of Medical Ethics 2021;47:662–669 https://jme.bmj.com/content/medethics/47/10/662.full.pdf

As Chambaere et al note, assisted dying does not replace palliative care, but becomes a vital and valid element within palliative care:

> "We found an increased demand for euthanasia in Belgium between 2007 and 2013, as well as growing willingness among physicians to meet those requests, mostly after the involvement of palliative care services. This finding indicates that, after 11 years of experience, euthanasia is increasingly considered as a valid option at the end of life in Belgium."[298]

In their study "Does legal physician-assisted dying impede development of palliative care? The Belgian and Benelux experience.", Chambaere and Bernheim examined the seven European countries with the highest rate of increase in palliative care (PC) provisions. The rate of increase was

> "the highest in the Netherlands and Luxembourg, while Belgium stayed on a par with the UK, the benchmark country. Belgian government expenditure for PC doubled between 2002 and 2011."[299]

Professor Jan Bernheim and Professor Rutger Jan van der Gaag noted that legislative change in Belgium and the Netherlands had been intrinsically linked with palliative care and they now boast some of the best palliative care provisions in Europe. Chambaere and Bernheim[300] note

> "The hypothesis that legal regulation of physician-assisted dying slows development of PC is not supported by the Benelux experience. On the contrary, regulation appears to have promoted the expansion of PC."

The recent Westminster assisted dying inquiry found that the introduction of assisted dying:

> 'has been linked with an improvement in palliative care in several

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[298] Chambaere et al (2015) *Correspondence: Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium*. The New England Journal of Medicine. https://www.nejm.org/doi/full/10.1056/NEJMc1414527

[299] Chambaere K & Bernheim, J (2015) *Does legal physician-assisted dying impede development of palliative care? The Belgian and Benelux experience*. Journal of Medical Ethics;41:657-660. https://jme.bmj.com/content/41/8/657.long

[300] ibid

‘jurisdictions.[301]

In the House of Commons’ assisted dying inquiry final oral evidence session in July 2023, Professor James Downar, Head of the Division of Palliative Care at the University of Ottawa, explained that since the introduction of an assisted dying law in 2016, Canada had seen

> “the strongest growth of palliative care in its history.”[302]

Downar reiterated this in his written statement:

> “funding/support for clinical palliative care has increased dramatically in much of the country since MAiD became legal”.[303]

Palliative Care Australia, which had originally opposed AD, informed the House of Commons’ assisted dying inquiry that it had come to the clear conclusion that the introduction of AD had augmented, not detracted from, palliative care.[304]

The recent Health and Social Care Committee’s assisted dying inquiry final report (29th February 2024)[305] concluded:

> “In the evidence we received, we did not see any indications of palliative and end-of-life care deteriorating in quality or provision following the introduction [of assisted dying]; indeed the introduction of [assisted dying] has been linked with an improvement in palliative care in several jurisdictions.”’

Assisted dying can be one of the choices within compassionate palliative care, and can lead to an improvement in resourcing for palliative care. Peer-

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[301] House of Commons Health and Social Care Committee Assisted Dying/Assisted Suicide Second Report of Session 2023–24 (2024) committees.parliament.uk/publications/43582/documents/216484/default/

[302] Stillwell, Nathan (2023) *The assisted dying inquiry: Everything important that was said. Humanists UK.* https://humanists.uk/2023/07/11/the-assisted-dying-inquiry-everything-important-that-was-said/#:~:text=In

[303] Downar, Prof James (2024) *Written evidence submitted by James Downar, MDCM, MHSc (Bioethics), FRCPC (ADY0161)* https://committees.parliament.uk/writtenevidence/115997/pdf/

[304] https://humanists.uk/2023/07/11/the-assisted-dying-inquiry-everything-important-that-was-said/

[305] Health and Social Care Committee’s assisted dying inquiry final report (29th February 2024). https://publications.parliament.uk/pa/cm5804/cmselect/cmhealth/321/report.html

reviewed research confirms that the introduction of the option of assisted dying either makes no difference, or in fact leads to a positive debate about, and improvement in, the quality of care.

It was noted in Westminster Parliamentary evidence that:

> "In jurisdictions adopting legislation, there were indirect system improvements and increased funding for palliative care that occurred alongside the introduction of assisted dying. It reflected debate around the importance placed upon assisted dying as a complement to palliative care and not as an alternative to palliative care."[306]

The Assisted Dying for Terminally Ill Adults (Scotland) Bill[307] 2021consultation cited some examples relevant to this particular question:

> "In 2015, the Palliative Care and Quality of Life Interdisciplinary Advisory Council (PCAC) was established in Oregon by Senate Bill 608. The legislation seeks to improve the lives of people who would benefit from palliative care and to facilitate better coordination of care. When the Australian State of Victoria passed assisted dying legislation, the government reviewed palliative care services in the area. As a result, an extra $72 million has been provided in Victoria to increase palliative care beds and access to home-based palliative care. In Western Australia, where assisted dying legislation was passed in 2019, the government announced a further AU$17.8 million for palliative care projects based on the recommendations of the Joint Select Committee Report on End of Life Choices. A report commissioned by Palliative Care Australia which examined assisted dying around the world found 'no evidence to suggest that palliative care sectors were adversely impacted by the introduction of legislation. If anything, in jurisdictions where assisted dying is available, the palliative care sector has further advanced.' Two years after assisted dying was legalised in Canada, the Minister of Health tabled a 'Framework on Palliative Care in Canada'. This framework provides a vision for palliative care in Canada and an implementation plan. The government committed funding of $6 billion over 10 years to improving palliative care with an

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[306] Duckworth, Prof Stephen (2022) *Written evidence submitted by Professor Stephen Duckworth OBE, DSc, PhD, FKC, MSc LRCP MRCS (ADY0002)* https://committees.parliament.uk/writtenevidence/114065/pdf/

[307] McArthur, Liam (2021) *Assisted Dying for Terminally Ill Adults (Scotland) Bill: 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*. https://www.parliament.scot/-/media/files/legislation/proposed-members-bills/assisted-dying-for-terminally-ill-adults-scotland-consultation-2021-final.pdf

additional $184.6 million to improve home and palliative care for indigenous communities.”

11) Positions held on Assisted Dying by British medical organisations.

It can be argued that continuing to keep the incurably and excessively suffering patient alive is not extending life so much as extending a bad death. Later versions of the Hippocratic oath have placed primacy on "first do no harm" and “I will abstain from all intentional wrong-doing and harm”, non-maleficence, and ensuring informed consent[308]. Respect for each patient’s autonomy and dignity has become central to the treatment of patients.

Even back in 2001, throughout the BMA/RC/RCN guidance, there is an implicit concern with the concept of ‘quality of life’ and it is emphasised that life should not be prolonged at any cost:

> ‘Prolonging a patient’s life usually provides a health benefit to that patient. Nevertheless, it is not an appropriate goal of medicine to prolong life at all costs with no regard to its quality or the burdens of treatment on the patient.’[309]

The British Medical Association and almost all other Medical Royal Colleges (Nursing, Psychiatrists, Physicians & Royal Society of Medicine) have now dropped their previous opposition to assisted dying.

11.1 The General Medical Council

Key elements within the GMC guidance are “Respect every patient’s dignity and treat them as an individual” and “Listen to patients and work in partnership with them, supporting them to make informed decisions about their care.”[310]

While the type of advice and support for a patient’s wishes remains limited by law, doctors are advised by the GMC to:

> “treat patients as individuals and respect their dignity and privacy; respect competent patients’ right to make decisions about their care,

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[308] Hajar, Rachel (2017) ibid https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5755201/

[309] BMA/RC/RCN (2001) Decisions Relating to Cardiopulmonary Resuscitation: a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. Journal of Medical Ethics, October 2001: 7. https://jme.bmj.com/content/27/5/310

[310] General Medical Council (as at Nov 7 2024) *The duties of medical professionals registered with the GMC*. https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/good-medical-practice/the-duties-of-medical-professionals-registered-with-the-gmc

> including their right to refuse treatment, even if this will lead to their death".[311]

The General Medical Council adopted a neutral stance on physician-assisted dying in 2021.

11.2 The Royal College of Nursing

In 2009 the RCN adopted a neutral stance and an approach to be

> "committed to supporting its members provide high quality end of life care to ensure a comfortable and dignified death, with the intention of alleviating distress."[312]

11.3 The British Medical Association

In 2019 the BMA published updated guidelines[313] on responding to patient requests for assisted dying, despite it remaining illegal. The guidance noted that there was a degree of ambiguity if a doctor's involvement in encouraging or assisting suicide concerned a close relative or partner[314], and recognised the likelihood of continuous sedation contributing to death in patients who are starving themselves, as it may,

> "when combined with a refusal of food and fluids, be construed as indistinguishable from assisted suicide."[315]

The document notes, but seeks to exclude from a definition of assisted suicide, 'withdrawing or withholding life-sustaining treatment', and 'pain and symptom relief', noting that

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[311] General Medical Council (as at Nov 7 2024) *When a patient seeks advice or information about assistance to die*. https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/when-a-patient-seeks-advice-or-information-about-assistance-to-die/when-a-patient-seeks-advice-or-information-about-assistance-to-die

[312] Royal College of Nursing (2009) *RCN position on assisted dying*. https://www.rcn.org.uk/About-us/Our-Influencing-work/Position-statements/rcn-position-on-assisted-dying

[313] British Medical Association (2019) *Responding to patient requests for assisted dying: guidance for doctors*. https://www.bma.org.uk/media/1424/bma-guidance-on-responding-to-patient-requests-for-assisted-dying-for-doctors.pdf

[314] ibid

[315] ibid

> "doctors can provide strong pain relief, even if that might risk hastening death".[316]

The guidance also notes that

> "a patient with capacity can make an informed and contemporaneous refusal of medical treatment and/or food and fluids, which must be respected."

This can include continuous sedation/induced coma. The document then goes on to offer guidance on the degree of involvement (in England and Wales) where "a prosecution is less likely to be required".[317]

Dr Andrew Green, the chair of the BMA's medical ethics committee, which leads on assisted dying, said that barring doctors from raising the option with patients would put unprecedented legal restriction on doctors – though he said no doctor should be obliged to mention the procedure.

> "After careful debate, we did conclude that there should be no requirement on doctors to raise the subject, but equally, they should be able to do so sensitively when they thought it was in the best interest of their patients."[318]

In 2021 the BMA adopted a neutral stance and published guidelines[319] on how they proposed Assisted Dying should operate.

Table 16[320] in section 146 of the Westminster Impact Assessment of the introduction of AD indicates the percentages of each type of BMA member willing to train and participate in AD.

Table 16 Proportion of BMA members who would actively participate in any way, if the law were to change so that doctors were permitted to prescribe drugs for patients to self-administer to end their own life, by profession (2020)[79]

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316 ibid

317 ibid

318 https://www.theguardian.com/society/2025/jan/15/doctors-to-speak-out-against-changes-to-proposed-assisted-dying-law-in-england-and-wales

319 The BMA's views on legislation on physician-assisted dying (2021). https://www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying

320 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

Profession	Base %	yes %	no %	undecided
Palliative medicine	604	10%	76%	14%
Clinical oncology	205	23%	60%	17%
Geriatric medicine	725	26%	56%	18%
Medical oncology	149	30%	52%	18%
Respiratory medicine	376	30%	51%	19%
General practice	9,525	32%	50%	18%
Cardiology	301	37%	49%	14%
Neurology	193	36%	48%	16%
Old age psychiatry	296	35%	47%	17%
General (internal) medicine	490	34%	46%	20%
Occupational medicine	141	35%	45%	20%
General surgery	683	39%	44%	17%
Public health medicine	330	41%	43%	16%
General psychiatry	927	37%	42%	20%
Emergency medicine	755	47%	35%	19%
Intensive care medicine	423	45%	35%	19%
Overall	**26,357**	**35%**	**47%**	**18%**

11.4 The Royal College of Physicians

In 2019 the Royal College of Physicians polled its 36,000 members on AD, and while 43.4% remained opposed, the majority of 56.6% were now neutral (25%) or supported AD (31.6%). The former Chair of the Committee on Ethical Issues in Medicine at the Royal College of Physicians has stated:

> "As a doctor I used to think palliative care was the answer. Now I realise that keeping people alive can be unspeakably cruel".[321]

11.5 The Royal College of Radiologists' (RCR) Faculty of Clinical Oncology

In 2019 the Royal College of Radiologists' (RCR) Faculty of Clinical Oncology polled its members and a minority (42.9%) opposed while the majority of 57.1% were now neutral (30.3%) or supported AD (26.9%).

[321] Duckworth, Prof Stephen (2022) Written evidence submitted by Professor Stephen Duckworth OBE, DSc, PhD, FKC, MSc LRCP MRCS (ADY0002) https://committees.parliament.uk/writtenevidence/114065/pdf/

11.6 The Royal College of General Practitioners

The Royal College of General Practitioners (RCGP) has also now moved from opposition to adopting a neutral position on assisted dying.[322] Also in 2019 the RCGP polled members, and the results were 2% abstain, 47% opposed, but by a narrow margin a majority had 11% neutral and 40% support outright.[323]

11.7 the Royal College of Surgeons

In February 2023, the Royal College of Surgeons surveyed its 17,631 members, and found 52% supported AD, 20% were neutral and only 25% opposed.

11.8 the Royal College of Anaesthetists

In 2024 the Royal College of Anaesthetists moved to a neutral position on assisted dying.

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[322] https://www.theguardian.com/society/2025/mar/14/professional-body-for-uk-gps-softens-position-on-assisted-dying-to-neutral

[323] British Medical Association (2023) Public and professional opinion on physician-assisted dying. https://www.bma.org.uk/media/4403/public-and-professional-opinion-on-physician-assisted-dying-report-v2.pdf

12 Medical staff and legal liability

12.1 Will medical practitioners face legal liability issues if they provide support in Assisted Dying?

In the end, this is the crux of the matter in relation to the law and AD in Scotland. There remains ambiguity in existing precedents and the law.

Downie notes that "in Baxter v Montana, the Supreme Court of Montana held that physicians who provide 'aid in dying' (so termed and limited to assisted suicide by the court) to terminally ill, mentally competent adult patients are shielded from criminal liability by the patient's consent."[324] When assisted deaths are permissible by law, and a medical practitioner follows the procedures as prescribed by law, the threat of liability is null.

By comparison, currently Scots case law simply fails to offer sufficient clarity and guidance on the legality of providing and/or administering a lethal substance to patients where the purpose is a hastened and compassionate death, hence the need for legislation.

12.2 Is there a risk of malpractice?

Poor reporting in the early years in the Netherlands has also been cited by opponents[325], but this is a criticism of poor reporting administration and not proof of malfeasance by doctors. Opponents of AD have tried to cite cases in the Benelux countries pointing to cases of assisted dying without consent. These have tended to be cases of heavy (and ultimately terminal) sedation in futile cases where the patient was in a coma or suffering from Alzheimers, but also dealing with a comorbidity such as terminal cancer. The level of deterioration of the patient, and the level of suffering is judged to be irreversible and progressive, and heavy sedation leads to death. This application of double effect existed legally in those countries before assisted dying legislation was introduced. It exists now legally in Scotland.

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[324] Downie, Joyce (2016) *Permitting Voluntary Euthanasia and Assisted Suicide: Law Permitting Voluntary Euthanasia and Assisted Suicide: Law Reform Pathways for Common Law Jurisdictions Reform Pathways for Common Law Jurisdictions*. QUT Law Review Volume 16, Issue 1, pp 84-112. https://digitalcommons.schulichlaw.dal.ca/cgi/viewcontent.cgi?article=1906&context=scholarly_works

[325] https://www.academia.edu/49721225/Euthanasia_and_assisted_suicide_good_or_bad_public_policy?email_work_card=view-paper

Guidelines and procedures can be clearly set by legislation. Procedures can be monitored and subject to regular reporting. However it is unrealistic to suggest that any medical system is perfect.

Opponents regularly seek to hold AD to a standard that is impossibly high for any area of medicine. They cite the the possibility of mistakes, poor practice, even bad actors. It is an uncomfortable truth that isolated mistakes and poor practice, some fatal, exist in every area of medical treatment. Holding AD hostage to negative speculation or to standards that no other area of medicine can guarantee is at best partial in approach.

In recent years there have been serious issues identified in UK medicine in areas such as post-natal and children's care or general support for the elderly, but post-natal care or elderly care is not denied to everybody else - the system ensures the processes are better monitored, improved and regulated. Palliative care has not been banned in every jurisdiction because abuses in hospices and care homes have been reported. Deep sedation has not been denied to patients because deaths have been the result in many cases. No system can ever be guaranteed to be perfect. In the end we find the compromise that offers the greatest benefits and the greatest protections. That said, supporters of AD would argue emphatically that no slippery slope, no coercion, no abuse of the vulnerable has been proven in relation to AD in any state where AD is legal in the 84 years since it it was first available in Switzerland. In addition, no state that has legalised AD has subsequently banned it for those reasons or any other.

From the very start, according to the proposed Scottish legislation, assisted dying will be one of the most tightly regulated areas of medical support. Expert medical practitioners, multiple safeguards and multiple stages are proposed in the decision to approve an assisted death to protect against lone bad actors. As in all other areas of medicine, there will also be a process of constant monitoring, evaluation and improvement.

As the international expert panel commissioned by the Royal Society of Canada observed:

> "In countries with a restrictive regime for assisted suicide and euthanasia, the incidence of non-voluntary cases was higher than of voluntary ones, as opposed to countries with permissive regimes. Apparently, therefore, the incidence of non-voluntary cases of assisted death is independent of the permissibility of euthanasia and assisted

suicide. It may even be the case that an open and liberal policy leads to a reduction in non-voluntary assisted dying."[326]

12.3 Are there risks of choosing AD for the wrong reasons?

Some in opposition to AD seek to separate the concept of unbearable pain from a more general concept of overall unbearable suffering. The latter takes into account non-pain related experiences of a chronic condition which can include feelings of isolation and loss of mobility, loss of social connections, poor quality care/living conditions, depression and what Kissane et al[327] refer to as 'demoralisation syndrome'.

In some cases it can appear that sufferers cite these experiences as stronger motivators to end their lives than pain, which may be normalised and taken for granted within the equation. Critics of AD express concern that individuals may be motivated to end their lives before pain becomes too severe, as a result of these other factors.

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[328] for the Scottish government of adult social care, which involved direct consultation with the Scottish disabled and chronically ill community, indicates a positive direction of travel in terms of protections and support for Scotland.

In Scotland, social care prioritises patients remaining in their own home for as long as their condition will allow and with support. Palliative care in Scotland, includes counselling and support.

Finally, it appears to make sense to place AD, as current Scottish proposals do, as a final additional option, after all other available social care resource, palliative and counselling support has been made available to the individual.

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[326] Royal Society of Canada Expert Panel (2011) *End-of-Life Decision Making*. Royal Society of Canada: 89 https://rsc-src.ca/en/end-life-decision-making

[327] https://www.researchgate.net/publication/12012374_Demoralization_syndrome-A_relevant_psychiatric_diagnosis

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

12.4 Will legalising AD undermine patient trust in doctors?

As to the argument that legalising medical aid in dying will undermine patient trust in the medical profession, this does not appear to be the case. Hall et a[329]l conclude that

> "despite the widespread concern that legalising physician aid in dying would seriously threaten or undermine trust in physicians, the weight of the evidence in the USA is to the contrary".

Anderson et al's study[330] of a highly diverse population

> "did not substantiate concerns that legalising medical aid in dying undermines patient trust in the medical profession."

12.5 Will medical staff be forced to administer an assisted death if it is in opposition to their personal beliefs?

MacLeod et al acknowledge that supporting an incurably suffering individual to achieve an assisted death may be a difficult or even insurmountable issue on a personal level for some staff.[331] Respect for personal autonomy is applied to all, including medical staff, in the current Scottish proposals. There is normally however a requirement in cases where medical staff are unwilling to participate that there is a mechanism to refer or transfer the individual's case. It is however generally agreed that nobody should be forced to participate unwillingly in the process, and there is a right to conscientious objection.

MacLeod et al[332] also cite various studies that indicate that providing a fatal prescription or administering a fatal dosage can place an emotional burden on some medical staff involved in AD, and this is a factor to consider in implementing a system that can include such support as counselling for

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[329] Hall et al (2005) *The impact on patient trust of legalising physician aid in dying.* J Med Ethics 2005;31:693–697. doi: 10.1136/jme.2004.011452 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1734062/

[330] Anderson et al (2024) *The Impact of Legalizing Medical Aid in Dying on Patient Trust: A Randomized Controlled Survey Study*. Journal of Palliative Medicine. doi: 10.1089/jpm.2023.0706. Epub ahead of print. PMID: 39167528. https://pubmed.ncbi.nlm.nih.gov/39167528/

[331] Macleod, Rod (2012) *Assisted or hastened death: the healthcare practitioner's dilemma. Global journal of health science.* https://www.academia.edu/24606646/

[332] ibid

medical staff, as well as the choice to not participate. White[333] notes that the best outcome is a health policy that provides a duty of care and support for all involved.

12.6 Will patient autonomy and best interests be protected?

General medical guidance already stresses the need to respect the wishes and rights of patients.

An assisted death remains a final resort, after all other possibilities have been offered and found wanting by a fully-informed and competent sufferer. As Adedayo et[334] al note:

> "Patients also need to be educated regarding end-of-life decision-making and what current technologies or lifesaving treatments they are able to choose or reject. Friend (2011) asserts that personal autonomy is achieved when patients have sufficient information to understand both their illness and prepare for the dying process."

The current Scottish Bill introduced by Liam McArthur ensures that there will be recognition that it is the individual's life, the individual's death, and the individual's choice. Each individual seeking an assisted death will:

- receive information about their palliative/end of life choices.
- receive counselling and information of existing alternative treatments and support.
- act on this information in order achieve a peaceful death at a time of their choosing.
- request & be granted assistance with dying if still desired.
- any such request will be subject to checks and balances to confirm no coercion, and will involve confirmation and approval by independent expert health professionals. The individual's choice will be assessed and confirmed as voluntary, and the request must be maintained in all the steps in the process, and decision making capacity is reviewed right up to the final confirmation of choice.

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[333] https://www.academia.edu/82903746/Voluntary_assisted_dying_peak_bodies_must_provide_practical_guidance?email_work_card=view-paper

[334] https://www.academia.edu/9665663/Euthanasia_and_Physician_Assisted_Suicide_The_History_Ethics_and_Healthcare_Implications?email_work_card=view-paper

- after approval, the individual is under no obligation to ever initiate an assisted death, and can simply hold the option in reserve, which often offers reassurance and a better sense of agency and autonomy.

13) **Are there exceptional circumstances that lie outside of provisions within the Assisted Dying for Terminally Ill Adults (Scotland) Bill)?**

The first thing to state is that those who support Assisted Dying may be best served by supporting the Bill. Liam McArthur's Assisted Dying for Terminally Ill Adults (Scotland) Bill is the fourth attempt[335] to introduce AD legislation in Scotland. The current Bill proposes to establish a clear and unambiguous position in law.

Supporters of the Bill can argue that

- the intractably suffering with terminal conditions will no longer need to fear an unbearable and traumatic death.

- the intractably suffering with terminal conditions will no longer feel forced to poison themselves alone and in danger of miscalculating the dose or in ignorance consuming something that causes unnecessary suffering or seeking (and possibly failing) to kill themselves in some other awful way.

- the intractably suffering with terminal conditions will no longer be forced into the trauma and expense of travelling abroad to a death before it is necessary, or forcing inequality upon the many who cannot afford to travel to Dignitas.

- the intractably suffering with terminal conditions will no longer be forced to kill themselves via dehydration and starvation.

- the intractably suffering with terminal conditions will be be protected in their attempt to die by having a process managed by medical staff.

- the intractably suffering with terminal conditions will be able to say goodbye surrounded by loved ones.

- the intractably suffering with terminal conditions will have the confidence of greater control over how they die, even if they choose not to use the dosage supplied.

[335] Previous attempts occurred in 2005, 2010 and 2013.

The objective of the current legislation is a worthy one. It is a common-sense, ethical and compassionate proposition, and will primarily benefit cancer sufferers who are expected to die within a period of time that qualifies the condition as terminal. The imperative must surely always be to help (as supporters of AD see it) as many who face intractable suffering as possible while ensuring the passage of the Bill. The proponents of the Bill have deliberately set very specific and tight criteria within there Bill with a view to enabling passage. That said, there are omissions within the Bill that can be explored.

13.1 Omissions

There is no provision for a medical professional to legally administer a lethal dose the bill. This excludes any consenting adult who is unable to self-administer a legal dose. This raises issues of justice and equality of provision.

The 'supply but do not administer' argument behind the proposed legislation appears to be an argument about how many angels can dance on the head of a pin. Apparently a doctor can place a pill in the hand of a patient seeking an assisted death, but not in the patient's mouth.

Is there, in reality, much difference between putting a pill in the hand or putting a pill in the mouth of a patient or injecting a substance?

If the patient is capable of swallowing or spitting out the pill, or indicate opposition in any way, then personal autonomy still exists, and the gap in the causal chain can be argued to still exist.

If the patient is incapable of lifting the pill to his or her mouth, but is able to choose whether to swallow or spit out, and a family member places the pill in their loved one's mouth, is the relative guilty of culpable homicide? Is that any different to, with consent, removing feeding from a patient? Is removing a tube from somebody's arm knowing that it will lead to their death much different from adding one in the same knowledge? It can be argued that both assisting to die and letting die as equally active and deliberate decisions. The scope of double-effect itself is at best ambiguous and a grey area in modern medicine. We know that paralysed individuals can refuse further treatment, although that can still cause intense suffering before death. We know that those suffering intractably and unbearably but not imminently terminal can

refuse food and water that, often in conjunction with deep sedation, will simply more slowly kill the patient as they weaken.

In the interests of equality and justice, why can't a consenting paralysed individual qualify for an assisted death? Will a modern day Kevorkian device be required, and legally allowed, that will deliver a dosage upon a certain number of consecutive blinks or moans? As there is provision for the patient, if unable to sign the declaration due to disability, to do so by proxy, then an forbidding the use of a proxy in administration of the dosage seems inconsistent.

There is no provision to legally supply or administer a lethal dose to a consenting patient who may not be classified as terminal, but who is suffering unbearably, incurably and intractably in the bill..

Where an autonomous individual sees the outcome of their requested death (ending intractable and unbearable suffering) as a personal benefit and not to their detriment, it is difficult to see how medical support in this aim contravenes medical ethics.

> "The argument for reform is particularly compelling when a condition overwhelmingly burdens a patient, pain-management fails to adequately comfort the patient, and only a physician can and is willing to bring relief."[336]

13.2 The difficulty defining terminal

The Scottish proposals do not specify a six month period, and although that has generally been understood, the lack of specificity makes sense. The bill defines terminally ill as follows:

> "For the purposes of this Act, a person is terminally ill if they have an advanced and progressive disease, illness or condition from which they are unable to recover and that can reasonably be expected to cause their premature death."[337]

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[336] Beauchamp, TL & Childress, JF. The Principles of Biomedical Ethics, 7th Ed. Oxford University Press (2013): p182

[337] https://www.parliament.scot/-/media/files/legislation/bills/s6-bills/assisted-dying-for-terminally-ill-adults-scotland-bill/introduction/bill-as-introduced.pdf

Specialists in any medical field can generally offer reasonable estimates of likely mortality from both experience and existing data. However such specificity in prognostication remains a complex challenge. Murray and Etkind argue that "uncertainty is inherent in advanced illness"[338], and note:

> "Prognostic eligibility criteria are limited by the fact that prognosis is inherently uncertain and there are no valid tools, tests, or clinical examinations that can reliably and safely identify that a person is expected to die within six months."[339]

They go on to note that:

> "Prognostic criteria are not included in the Dutch, Belgian, and Swiss laws or the proposed legislation in Scotland. Canada removed prognostic criteria from assisted dying legislation to expand eligibility to people with intractable, intolerable suffering who are not approaching the end of life, and in response to legal challenges and concerns about discrimination."[340]

The criterion of intractable, unabatable and intolerable suffering, as confirmed primarily by the patient and recognised by medical specialists would appear to offer more accuracy in terms of need.

If someone is suffering incurably and unbearably, and all other options are insufficient, then having the choice of an assisted death will offer great and compassionate relief. Other sufferers whose condition is not predicted to end their life within six months are excluded from current proposals. We can illustrate this devil's bargain with a version of the "trolley problem".

In this scenario you are presented with two people you care about, both with incurable conditions that cause them equal unbearable suffering. In both cases palliative care cannot bring sufficient relief to make life bearable. One of your loved ones is likely to die in a matter of months. The other will continue suffering for years. You are only allowed to offer an assisted death to one. Who would you prioritise?

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[338] Scott A Murray & Simon Noah Etkind. Assisted dying and the difficulties of predicting end of life: The inherently uncertain trajectories of terminal illnesses pose challenges for clinicians. BMJ 2025;388:r490. https://www.google.com/url?sa=t&source=web&rct=j&opi=89978449&url=https://www.repository.cam.ac.uk/bitstreams/72512c35-634e-44a9-a6bd-3ae390891cf2/download&ved=2ahUKEwjmzJ6YhNOMAxVdVEEAHZm_LkkQFnoECBgQAQ&usg=AOvVaw2tBC3YoWHapKrMy_I8TZFm

[339] ibid

[340] ibid

Of course the only acceptable answer is that in a truly compassionate society we would help both. As Polly Toynbee[341] notes:

> "Most people travelling to die at Dignitas in Switzerland have longer than six months to live. Polling for Humanists UK shows a majority of voters support there being no time limits for those with degenerative diseases such as multiple sclerosis, by 73% to 9% against."[342]

As Jackson[343] states:

> "unbearable and irremediable suffering is not confined to those who are imminently dying, and if compassion is our justification for legalisation, it is that sort of suffering which should be the criterion, not terminal illness, especially since someone with longer to live will experience *more* suffering, quantitatively speaking, than someone whose death is expected within days"

As other states and countries have recognised, there are 'exceptional circumstances'. Limiting access to assisted dying only to those who are expected to die within a limited time-frame seems arbitrary and irrational. The degree of unabated and incurable suffering is surely the most logical metric. There are chronic suffers who do not have a 'terminal' condition but whose trajectory toward death is unbearable and inevitable, with no prospect of improvement.

Canada, Spain, Belgium or the Netherlands, for example, employ broader and more inclusive criteria, "that medical assistance in dying should be available as a means to address intolerable suffering outside of the end-of-life context"[344].

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[341] https://www.theguardian.com/commentisfree/2025/feb/14/campaign-against-assisted-dying-bill-kim-leadbeater-public-support?utm_term=Autofeed&CMP=fb_gu&utm_medium=Social&utm_source=Facebook&fbclid=IwY2xjawIfn3FleHRuA2FlbQIxMQABHaF7tbuM-QymN81AgIRDCBO5klBIqTA9lXPr-nCrd0poeTg5f48njV-6lw_aem_HjEl6SqTQxmxi-QxdJdjMg#Echobox=1739527320

[342] https://humanists.uk/2024/10/16/new-poll-shows-every-constituency-backs-assisted-dying/

[343] Jackson, Emily and Keown, John. Debating Euthanasia Hart, Oxford, 2012 (reprinted 2013 & 2014): 79

[344] Downie J, Schuklenk U (2021) *Social determinants of health and slippery slopes in assisted dying debates: lessons from Canada.* Journal of Medical Ethics;47:662-669. https://jme.bmj.com/content/47/10/662

Rather than placing a relatively arbitrary and guess-work time-limit, access to assisted dying support, the Canadian system applies the criteria:

1) Serious and incurable illness, disease or disability;

2) Advanced state of irreversible decline in capability;

3) Illness, disease or disability or state of decline causing enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.[345]

In the Netherlands[346] [347], the criteria are:

1) the request is autonomously made;

2) the patient's suffering is unbearable with no prospect of improvement;

3) the patient is fully aware of his condition and prognosis, and the request is voluntary and persisting over time;

4) the choice is made after the exhaustion of all alternatives;

5) a second independent physician has confirmed the conditions; and

6) the procedure is performed in a medically appropriate way.

Why exclude those tortured by unbearable suffering with no prospect of improvement who are doubly unfortunate in that they will suffer unbearably for a longer period of time before dying?

58% of doctors believe that, if the law were to change, patients with physical conditions causing intolerable suffering which cannot be relieved should be able to access an assisted death.[348]

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[345] Downie, J (2023) *MAiD in Canada: Cautionary Tale or Model?* QUT Australian Centre for Health Law Research. https://research.qut.edu.au/achlr/2023/04/28/maid-in-canada-cautionary-tale-or-model/

[346] Radbruch et al (2016) Euthanasia and physician-assisted suicide: A white paper from the European Association for Palliative Care. Palliative Medicine Volume 30, Issue 2 Pages 101-192 https://journals.sagepub.com/doi/epub/10.1177/0269216315616524

[347] Banović & Turanjanin: Euthanasia: Murder or Not: https://www.academia.edu/8923488/Euthanasia_Murder_or_Not_A_Comparative_Approach?email_work_card=title

[348] https://www.mydeath-mydecision.org.uk/professional-and-public-opinion/

Current proposals establish a 'Devil's Lottery'. Limiting the choice of assisted dying to sufferers likely to die within a set period of time may be a necessary compromise for assisted dying legislation to pass, but it is not a logical one. It condemns all other incurable sufferers to continue suffering or to choose a "bad death" i.e. by drugging a person until their cognitive faculties are destroyed and a social death is experienced; inflicting an induced coma and/or dehydration and starvation on the sufferer and a traumatic deathwatch on their loved ones; or a suicide without safeguards, and "often by horrendous means"[349] that may fail. The head of the Western Australian police union came out in support of voluntary assisted dying stating:

"People experiencing an irreversible deterioration in their health are taking their own lives, often in horrific circumstances. We need a compassionate assisted dying law to give people in certain circumstances a choice to die in a dignified way".[350]

Dignity in Dying in the UK now estimate between 300 and 650 dying people end their own lives every year and as many as 6,500 attempt to do so.[351] The ban on assisted dying did not stop terminally ill people ending their lives, but forced many to find alternative ways.

> "This results in deaths that are needlessly violent, unsafe and damaging to those who are left behind."[352]

Despite statistics being extremely difficult to collate, the Office for National Statistics offers an estimate of 14.2% of suicides are by those with seriously chronic and terminal conditions.[353] These are lonely and often messy deaths. Many could have lived longer and had a better death if AD and proper medical supervision was provided for all who seek it who suffer intractably.

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[349] Anaf, Dr Julia personal submission, quoted in Victorian Committee Report (n 7) 197, cited by Del Villar, K, Willmott, L & White, B (2020) *Suicides, Assisted Suicides and 'Mercy Killings': Would Voluntary Assisted Dying Prevent these 'Bad Deaths'?* 46(2) Monash University Law Review: 12. https://ssrn.com/abstract=3544476

[350] Voluntary Assisted Dying South Australia (viewed 07/11/24). *The Facts About Assisted Dying.* https://www.vadsa.org.au/the_facts

[351] Riley L & Hehir D (2021) Last Resort: The hidden truth about how dying people take their own lives in the UK:6. Dignity in Dying. https://www.dignityindying.org.uk/wp-content/uploads/Last-Resort-Dignity-in-Dying-Oct-2021.pdf

[352] Dignity in Dying. Last Resort. https://www.dignityindying.org.uk/wp-content/uploads/Last-Resort-Dignity-in-Dying-Oct-2021.pdf

[353] ibid: 70

In Del Villar & White's analysis[354], for example, sufferers of Parkinson's disease or multiple sclerosis (together 36% of suicides amongst those who took their own lives in Australia due to "incurable, advanced, progressive" conditions that caused unbearable suffering) would not qualify for AD support under the criterion in Australia of 6-12 month life expectancy. As they note in their study, (citing Coroner Caitlin English's: Victorian Committee Report), if the offer of the choice of an assisted death is too narrow, "bad deaths" will persist - people taking their own lives in 'desperate, determined and violent ways" will continue if "similarly narrow [voluntary assisted dying] laws are enacted."[355]

Some critics of current proposals in Scotland argue that personal agency and the degree of unabatable and unbearable suffering should have primacy in consideration of qualification for AD support. As things stand with current proposals there remains a compromise that leaves longer-term sufferers to continue suffering over an extended timeframe.

The exclusion of special cases does not protect and prolong lives, but instead condemns others to a drawn-out miserable death against their wishes.

13.3 So why are the Holyrood (and Westminster) proposals so narrow and conservative?

It is possible that the Bill's architects hope that by limiting access to AD to those who are likely to die within a short period of time, they are removing the risk of coercion. They have also included legal sanctions for coercion. All this in spite of any evidence of coercion (see Section 4) or risk to the disabled and chronically ill (see Section 5).

Two previous attempts to introduce Assisted Dying legislation in Scotland failed. The proponents of the current Bill wish for it to pass. Opposition is very well-funded, and most of the press either oppose or maintain a neutral stance on assisted dying.

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354 https://www.academia.edu/42071419/Suicides_Assisted_Suicides_and_Mercy_Killings_Would_Voluntary_Assisted_Dying_Prevent_these_Bad_Deaths?email_work_card=view-paper

355 Del Villar, K, Willmott, L & White, B (2020) *Suicides, Assisted Suicides and 'Mercy Killings': Would Voluntary Assisted Dying Prevent these 'Bad Deaths'?* 46(2) Monash University Law Review: 12. https://ssrn.com/abstract=3544476

Bache[356] notes in his research on voting patterns related to AD in the past how surprising it has been that UK politicians have remained so out of step with public sentiment on the issue. Bache found that:

> "Conscience issues such as AD/AS are complex moral issues, which provide a particular challenge for politicians. They are 'not the usual kind of stuff of politics' and MPs are 'reticent' to deal with them."[357]

and that

> "many MPs seek to avoid the issue if possible, and, when pushed to vote, these MPs have tended to default to the safety of the status quo".[358]

Parliamentarians in the past tended to vote on party lines, and are risk-averse, possibly vulnerable to pressure from vociferous campaigners constituents, and therefore:

> "'routinely avoid responsibility' where possible for fear of offending a vocal minority of constituents with passionate views".[359]

Where change has iteratively occurred through court rulings in the Netherlands and Canada, the scope of ultimate AD legislation has been broader. If recommendations came first from a citizens' assembly, more likely reflecting public opinion, we can speculate that the final legislation could be

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[356] Bache, Ian. How (and when) does party matter? Explaining MPs' positions on assisted dying/assisted suicide. Parliamentary Affairs (2025) XX, 1–21 Advance Access Publication 1 March 2025. https://www.academia.edu/128612404/How_and_when_does_party_matter_Explaining_MPs_positions_on_assisted_dying_assisted_suicide

[357] Bache, Ian. How (and when) does party matter? Explaining MPs' positions on assisted dying/assisted suicide. Parliamentary Affairs (2025) XX, 1–21 Advance Access Publication 1 March 2025. https://www.academia.edu/128612404/How_and_when_does_party_matter_Explaining_MPs_positions_on_assisted_dying_assisted_suicide

[358] Bache, Ian. How (and when) does party matter? Explaining MPs' positions on assisted dying/assisted suicide. Parliamentary Affairs (2025) XX, 1–21 Advance Access Publication 1 March 2025. https://www.academia.edu/128612404/How_and_when_does_party_matter_Explaining_MPs_positions_on_assisted_dying_assisted_suicide

[359] Bache, Ian. How (and when) does party matter? Explaining MPs' positions on assisted dying/assisted suicide. Parliamentary Affairs (2025) XX, 1–21 Advance Access Publication 1 March 2025. https://www.academia.edu/128612404/How_and_when_does_party_matter_Explaining_MPs_positions_on_assisted_dying_assisted_suicide

broader. However, the precedents in both Scottish and Westminster parliaments have demonstrated how politicians appear to remain reluctant to reflect public opinion in the final votes.

The majority of people who will suffer intractably and would consider Assisted Dying fall within the scope of the definition of terminal illness in Liam McArthur's Bill. The adoption of this as the basis for accessing Assisted Dying will serve many people. While a sense of justice may cause feeling that the proposed legislation should go further, there is a danger, bearing in mind the continued opposition in some quarters and the recognised caution of politicians, of allowing the perfect to obstruct the good. The McArthur Bill, if passed, will provide great comfort to many people who would otherwise suffer terribly and unnecessarily.