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**Briefing notes for giving evidence to the Scottish Committee on the AD Bill**

**The Terminally Ill Adults (End of Life) Bill introduced by Kim Leadbeater MP in October 2024 seeks to permit doctors to supply adults with a terminal illness with lethal drugs to end their own lives (assisted suicide).**

1. **Doctors who spend the most time caring for terminally ill people oppose assisted suicide**

Doctors specialising in palliative medicine and care of the elderly overwhelmingly reject changes in the law to decriminalise doctor-assisted suicide[[1]](#footnote-1),[[2]](#footnote-2) as reflected by the position statements of the Association for Palliative Medicine[[3]](#footnote-3) and the British Geriatrics Society.[[4]](#footnote-4) The Royal College of General Practitioners remains opposed to assisted suicide,[[5]](#footnote-5)and no official medical bodies support a change in the law.[[6]](#footnote-6)

Association of Palliative Medicine Survey in Scotland on this proposed Bill in 2022.

95% would not prescribe lethal drugs

97% would not administer lethal drugs

98% said it had no place in health care

43% said they would leave their post if this were practised in their hospice or hospital

Royal College of GPs strongly opposed this Bill in their written evidence

British Society of Geriatricians released a position statement

We are concerned that vulnerable people might feel under pressure to opt for assisted suicide especially if they are in a controlling or coercive relationship.

COERCION

* Coercive control is difficult to recognise- its onset can be subtle and insidious.
* Yet it is common- WHO estimate 15% of older adults suffer some abuse worldwide.
* Those more at risk are those who have physical and mental illness and cognitive decline.
* Age Concern Scotland estimate 7-9% elder abuse in Scotland
* Crucially, Doctors are not trained to detect coercion.
* This Bill does not require
	+ that the doctors have any prior knowledge of the patient.
	+ that there is any consultation with any person who might know the patient- next of kin, district nurse, friend.
	+ It does not require a multi-disciplinary assessment as would be usual in any other major medical decision-making

2 key organisations raised concerns about coercion

* Royal College of GP states in its written evidence to this committee that detecting coercion can be beyond the remit of the usual GP
* Social Work Scotland raised concerns that an effective complex and holistic approach could only be achieve by a multidisciplinary team.

Pressure may not be deliberate or malicious but due to feeling a burden on carers. , but from feeling a burden on carers.

* Cerebral Palsy Scotland cited risk of coercion of vulnerable groups as one of their key concerns. 50% of their community stated that their care package did not meet their needs.
* In Oregon around one- half of people cite ‘feeling a burden on caregivers’ as one of the reasons they cite as choosing assisted dying.

Reasons include recognition of the vulnerability of many patients to external and internal pressures, constrained decision making; diagnostic inaccuracy, prognostic inaccuracy, and the complexities of assessing fluctuating mental capacity. Treatable conditions such as depression are common in terminal illness and are linked to desire for hastened death but are often under recognised by doctors.

Trust is the foundation of the clinician-patient relationship. The fact that a doctor or nurse might initiate a conversation, or even instigate a hastened death, when a patient is ill, at their most vulnerable and seeking care changes the relationship. There must be clarity that a doctor will never intentionally cause harm to a patient. The clear prohibition of medically-assisted killing (assisted suicide or euthanasia) in current law safeguards the vulnerable and provides a safe therapeutic space for terminally ill people.

1. **The medical assessments in this Bill will not safeguard vulnerable people from external pressures**

Doctors are not trained to detect coercion. Coercive control can be difficult to recognise because it operates insidiously and subtly, and the victim does not necessarily recognise it for what it is. Best practice with terminally ill or elderly patients requires comprehensive assessment by members of a multi-professional team.[[7]](#footnote-7) This acknowledges the complex multi-factorial, physical, social, psychological and spiritual needs of people with advanced illness. These detailed assessments take time and liaison between professionals to explore the most effective treatment, care and support for each patient’s needs and priorities. The two independent medical assessments in this Bill do not require the doctors to have cared for the patient or assessed them before, and no level of specialisation is required. The doctors are, in any case, unlikely to be fully independent. The coordinating doctor will choose a second doctor from a small pool – in countries where assisted suicide is practiced only 1-2% of doctors opt to be involved in the process (e.g. 1.1% of doctors in Oregon)[[8]](#footnote-8) – and can seek a further opinion if the first does not concur.

The vital role of social workers in the detection of coercion and provision of safeguarding is ignored by the Bill, as is the role of nursing staff who often spend more time with patients in care settings.

1. **Suicide is not a truly free choice when there are inequities in access to high quality care**

Beyond coercion, there are many external factors that constrain a person’s decision-making in the context of advanced illness – such as limited practical and financial freedom, poor housing, or inability to live fully independently without practical and financial support from others. A wish to die may be transient and treatable with explanation, psychological support and appropriate medication. Increased waiting times in stretched NHS and Social Care services are leading to delayed diagnoses and treatment,[[9]](#footnote-9) but this Bill would make access to assisted suicide available within weeks and fully funded. People cannot make a true choice about assisted dying if they do not have access to care when they need it, day or night. This includes general and specialist palliative care, effective pain management, social care and psychological support.

1. **The medical assessments in this Bill will not safeguard vulnerable people**

The Bill disadvantages the most vulnerable in society in subtle ways. Terminally ill and disabled individuals have been shown to be prone to devalue themselves because they feel a burden, worry about receiving care on their terms, or feel alone and unsupported in meeting their needs. Pressure is subtle and may be exerted by families and clinicians. Patients feel a burden in all sorts of unspoken ways. The Oregon Health Authority annual reports show that approximately half those choosing assisted suicide feared being a burden on family, friends or caregivers6. The Bill does not require doctors or courts to involve a person’s relatives or friends in the assessment processes, even though this would be best practice in most areas of complex care planning. In other countries this has led to cases of assisted suicide being completed without the knowledge of the person’s family.

1. **The 6-month definition of ‘terminal illness’ oversimplifies doctors’ ability to estimate prognosis**

The commonest question asked of palliative care clinicians is ‘how long have I got?’. This is often a patient’s most important question, and one of the hardest for doctors to answer. Multiple clinical studies show medical prognosis to be an inaccurate science, made more challenging if a doctor has not monitored a patient’s condition over time. Errors in diagnosis for severe, life-threatening conditions can be as high as 20%[[10]](#footnote-10). The condition and appearance of patients who are uncomfortable or distressed can improve dramatically when appropriate care and support are provided, impacting estimated prognosis and reducing peoples’ desire for hastened death. Advances in medical treatment continue to dramatically improve the outlook for serious diseases, in some cases (for example in oncology and cardiology) increasing average prognosis from months to years. Specialist knowledge is therefore required to offer a prognosis informed by an understanding of all available treatment options. Such specialist assessment is not required by the Bill.

1. **The definition of ‘terminal illness’ includes patients with otherwise manageable or treatable conditions**

The definition of terminal illness in the Bill is broad enough to include people with manageable conditions such as diabetes, should they elect to discontinue treatments. In some countries conditions such as hernias, arthritis and anorexia nervosa have been classified as ‘terminal illnesses’ and approved for assisted suicide.[[11]](#footnote-11)

1. **Assisted suicide does not guarantee a dignified death**

In the UK, use of prescription medicines is based on clinical trials providing evidence of their benefits, effectiveness and unwanted harms. There are no drugs in UK clinical practice that are licensed for the purpose of causing death by suicide. Assisted suicide substances have not been tested for their effectiveness in causing death, or for rates of unwanted side effects. Therefore, the drug combinations used for assisted suicide are to some degree experimental and any ‘substance’ licensed for this purpose will be based on experience from other countries. The state of Oregon has used a number of different drug combinations since assisted suicide was introduced in 1997.6,[[12]](#footnote-12) In recent years combinations of 4-5 drugs have been used, often >100 tablets, and there are significant gaps in side effect reporting (no data reported for 63% deaths in 2023). Prescribing with this level of uncertainty and lack of safety and efficacy data would be unthinkable in other areas of UK medical and pharmacy practice.

Proponents of assisted suicide appear to believe that ingestion of a prescribed ‘substance’ will ensure death quickly, peacefully and uneventfully. This is not always the case. Other countries such as Oregon report an unpredictable time course to death and a concerning level of side effects from the substances prescribed.6Side effects under the Death with Dignity Act include seizures, vomiting, regurgitation and regained consciousness. Death may not occur in all cases (see below) and the time to death varies widely. In 2023 half of the 67% of people with data available took more than 53 minutes to die, with the longest time to death being 137 hours (5.7 days). The Bill requires that a doctor remains with the patient until they die but the variable time to death would make this impracticable in community settings.

1. **Professional dilemmas arise with complications of assisted suicide**

This Bill requires the co-ordinating doctor to discuss a person’s wishes in the event of complications arising in connection with self-administration of the approved ‘substance’. There is, however, no indication of what the doctor is supposed to do with the resulting information, nor what they are supposed or allowed to do if death is very delayed or if the person awakes after becoming unconscious. Palliative care professionals are the most experienced in managing symptom control in dying patients but are the least likely to be willing to be involved in the assisted suicide process.

1. **The conscience clauses in the Bill do not adequately protect health professionals’ freedom of conscience**

The Bill requires *effective referral*, which many would find amounts to complicity. Provision of assisted suicide through the NHS would disrupt and undermine care. The BMA recommends that assisted dying be delivered through an entirely separate service.[[13]](#footnote-13) The Bill’s ‘opt-out’ clause for medical practitioners is at odds with the BMA’s recommendation that doctors should only be required to ‘opt in’ to any involvement. The requirement for doctors with a conscientious objection to refer someone seeking assisted suicide to a doctor willing to provide assessment is problematic for many NHS staff, particularly those with religious affiliation’[[14]](#footnote-14) This will prompt doctors to leave the profession or alter career choices. In Scotland 43% of palliative care doctors would resign if their organisation offered assisted suicide.[[15]](#footnote-15)

1. **The safeguards in this Bill cannot prevent future expansion to groups that we seek to protect**

It is impossible for this Bill to provide effective safeguards against expansion of assisted suicide to other groups following future amendments to the law under equality legislation. Canada introduced assisted dying for the terminally ill in 2016. This has since been extended to those who are disabled but not dying in 2021 and planned for those who are solely mentally ill in 2027. In Holland and Belgium assisted dying laws have extended to provide euthanasia to those with learning disability, children and people lacking capacity to consent such as those with advanced dementia.

1. **This Bill will undermine suicide prevention**

Although it is often suggested that (unassisted) suicide in those with severe physical illness will be prevented, there is no evidence to support the claim. In jurisdictions where assisted suicide/euthanasia is legal suicide rates either stay the same or increase[[16]](#footnote-16). For example, in Oregon in the last decade assisted suicide deaths have increased 5-fold while the suicide rates have increased by 20%.

1. **This Bill will further undermine the provision of palliative care**

Assisted suicide threatens to undermine gains in early access to palliative care which have been proven to increase both quality and length of life[[17]](#footnote-17). At a time of severe inequalities of access to healthcare, many terminally ill people are dying without the care and support they need to live well until the end of their lives and to die with dignity. Hospices receive an average of only one third of their funding from the Government and rely on charitable fundraising to meet the shortfall, with many closing beds or reducing staffing in the face of 2024’s financial pressures[[18]](#footnote-18). A recent critical review has confirmed the relative adverse impact of assisted dying legislation on palliative care service provision[[19]](#footnote-19).

***Please oppose this Bill: the current law* is *the safeguard***

*Our Duty of Care* is a group of healthcare professionals across the UK who oppose the intentional killing of patients by assisted suicide or euthanasia. We are a campaign that is financed and administered by the Care Not Killing alliance.

Further information can be accessed at <http://ourdutyofcare.org.uk>/

1. https://apmonline.org/wp-content/uploads/APM-survey-on-Assisted-Suicide-website.pdf [↑](#footnote-ref-1)
2. [bma-physician-assisted-dying-survey-report-oct-2020.pdf](https://apmonline.org/wp-content/uploads/bma-physician-assisted-dying-survey-report-oct-2020.pdf) [↑](#footnote-ref-2)
3. https://apmonline.org/wp-content/uploads/APM-Position-Statement-on-Assisted-Dying-October-2024-v2.pdf [↑](#footnote-ref-3)
4. https://www.bgs.org.uk/resources/bgs-position-statement-on-assisted-dying [↑](#footnote-ref-4)
5. <https://www.rcgp.org.uk/representing-you/policy-areas/assisted-dying> [↑](#footnote-ref-5)
6. https://www.rcp.ac.uk/news-and-media/news-and-opinion/the-rcp-clarifies-its-position-on-assisted-dying [↑](#footnote-ref-6)
7. https://www.nice.org.uk/guidance/ng142/chapter/Recommendations#assessing-holistic-needs [↑](#footnote-ref-7)
8. https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year26.pdf [↑](#footnote-ref-8)
9. Darzi, A. 2024. Independent Investigation of the National Health Service in England. https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england/independent-investigation-of-the-national-health-service-in-england-accessible-version [↑](#footnote-ref-9)
10. ML Graber; RM Wachter & CK Cassel. Bringing Diagnosis into Quality and Safety Equations. JAMA 2012, 308, 12 pp 1211-2 doi:10.1001/2012.jama.11913 [↑](#footnote-ref-10)
11. Regnard C, Worthington A, Finlay I. Oregon Death with Dignity Act access: 25 year analysis. *BMJ Supportive & Palliative Care* 2024;**14**:455–461. <https://doi.org/10.1136/spcare-2023-004292> [↑](#footnote-ref-11)
12. A Worthington, I Finlay, C Regnard. Efficacy and safety of drugs used for assisted dying. Br Med Bull. 2022 142 (1) 15-22. https://doi.org/10.1093/bmb/ldac009 [↑](#footnote-ref-12)
13. <https://www.bma.org.uk/media/p14iljtc/bma-briefing-terminally-ill-adults-end-of-life-bill-2r.pdf> [↑](#footnote-ref-13)
14. https://britishima.org/advice/assisted-dying-assisted-suicide-and-euthanasia-position-statement/ [↑](#footnote-ref-14)
15. https://apmonline.org/wp-content/uploads/APM-Survey-of-AD-Impact-on-PC-FINAL.pdf [↑](#footnote-ref-15)
16. S Girma, D Paton. Is assisted suicide a substitute for unassisted suicide? European Economic Review 2022;145:104133. https://doi.org/10.1016/j.euroecorev.2022.104113 [↑](#footnote-ref-16)
17. J Temel et al. Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer. N Engl J Med 2010;363:733-742. doi:10.1056/NEJMoa1000678 [↑](#footnote-ref-17)
18. https://www.nursingtimes.net/workforce/hospice-to-lay-off-dozens-of-staff-amid-palliative-care-funding-crisis-28-06-2024/ [↑](#footnote-ref-18)
19. https://bioethics.org.uk/media/mhrka5f3/suicide-prevention-does-legalising-assisted-suicide-make-things-better-or-worse-prof-david-albert-jones.pdf [↑](#footnote-ref-19)