Submission No 41

INQUIRY INTO PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

Organisation: The Anscombe Bioethics Centre

Date Received: 22 November 2021

Voluntary Assisted Dying Bill 2021 (NSW)
Submission by the Anscombe Bioethics Centre, Oxford, UK

Summary

0.1 There is no necessity for NSW for follow other Australian states in legalising euthanasia and there is advantage not doing so, not least to gather more evidence.

0.2 The terminology of VAD is less clear than the long established terms voluntary euthanasia and (physician) assisted suicide.

0.3 There is theoretical reason and empirical evidence for believing that legalising euthanasia would lead to a 'slippery slope' adversely affecting disabled persons.

0.4 There is good evidence that legalising assisted suicide will increase rates of self-initiated death and will not help prevention of (non-assisted) suicide.

0.5 The individual and institutional conscience clauses are flawed and, even if these clauses were improved, there would likely be progressively less tolerance of conscientious objection over time.

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This submission

0.6 The Anscombe Bioethics Centre, currently based in Oxford, is the oldest centre for healthcare ethics in the United Kingdom or Ireland, founded in 1977.

0.7 In addition to my role as Director of the Anscombe Bioethics Centre, I am Research Fellow at Blackfriars Hall, Oxford University, Professor of Bioethics at St Mary's University, Twickenham, Vice-Chair of the Ministry of Defence Research Ethics Committee, and an examiner and lecturer for the Society of Apothecaries Diploma in the Philosophy of Medicine. I have served on the steering group of the End-of-Life Care Audit - Dying in Hospital and was a member of a working party of the General Medical Council which helped draft its 2010 guidance on *Treatment and Care Towards the End of Life*. My publications include *Approaching the End,* Oxford: Oxford University Press, 2007; *A Practical Guide to the Spiritual Care of the Dying Person*, London: CTS, 2010 (contributor and co- editor); and *Euthanasia and Assisted Suicide: Lessons from Belgium*, Cambridge: Cambridge University Press, 2017 (contributor and co- editor with Chris Gastmans and Calum MacKellar). In addition to numerous journal articles and book chapters.[1]

1. Key Factors for NSW to Consider

1.1 The United States is an example of a federally constituted nation where there is no consensus or uniformity of statutory or juridical decisions among states on the question of 'assisted dying'. Ten out of fifty states in the US have legalised some form of it, but it is by no means a foregone conclusion that other states will follow suit and

[1] Including among others: David Albert Jones, 'Virtue Theory and the Lawfulness of Withholding or Withdrawing Treatment or Care' in Thana Campos, Jonathan Herring and Andelka M. Phillips (eds.) *Philosophical Foundations of Medical Law* Cambridge: Cambridge University Press, 2019, pp. 139-150; David Albert Jones, 'Assisted dying and suicide prevention' *Journal of Disability & Religion*, 22.3 (2018): 298-316; David Albert Jones, 'Judgment 2—Airedale NHS Trust v Bland [1993] AC 789' in S. Smith et al. *Ethical Judgments: Re-writing Medical Law*. Oxford: Hart, 2017. pp. 71-76; David Albert Jones and David Paton, 'How does legalization of physician assisted suicide affect rates of suicide?' *Southern Medical Journal* (2015) 108.10: 599-604; David Albert Jones, 'Death by Equivocation: A manifold definition of terminal sedation' in Sigrid Sterckx et al. *Continuous sedation at the end of life: Ethical Perspectives*. Cambridge: Cambridge University Press, 2013, pp. 47-64; David Albert Jones, 'Is dignity language useful in bioethical discussion of assisted suicide and abortion?' in Christopher McCrudden (ed.) *Understanding Human Dignity*. London: British Academy and Oxford University Press, 2013, pp. 529–42; David Albert Jones, 'Is there a logical slippery slope from voluntary to non-voluntary euthanasia?' *Kennedy Institute of Ethics Journal* (2011) 21.4: 379-404.

it is extremely unlikely that all states will do so. The state of New South Wales should not consider the fact that other Australian states have legalised some form of voluntary assisted dying (VAD) as making it inevitable that such legislation will be passed in this state. Given the size of its population and its comprehensive healthcare system, NSW can and should determine its own policy and law in relation such matters.

1.2 Evidence from other jurisdictions, such as the Netherlands and Oregon, show the possible, likely, and in some respects certain consequences of such laws (*e.g.*, that safeguards are largely ineffective as they are unenforceable).[2] However, it has yet to be seen precisely what effect similar legislation will have in Australia. To have a better estimate of the likely consequences of VAD legislation in the specific socio-cultural context of Australia requires the consideration of data from Australian states that have legalised VAD and a comparison with states that have not done so. Tasmania, South Australia and Queensland have yet to fully operationalize their laws and there is very limited data and scant research on the impact of the change in the law in Victoria and Western Australia.

1.3 Will rates of non-assisted suicide and of self-initiated death increase in VAD states relative to non-VAD states in Australia, as has happened in the United States?[3] We cannot be sure but we will have a better idea over time only if not all Australian states legalise VAD. The same holds of other possible consequences. From this practical perspective, it is inexplicable why NSW should consider embracing VAD before there is significant comparative data from different Australian states. This should not be taken to imply support for VAD if the data, however implausibly, shows none of the effects that other jurisdictions have seen since passing similar laws. The Anscombe Bioethics Centre is wholly opposed to all forms of assisted suicide and euthanasia. It simply serves to highlight that, if NSW does not legalise VAD, not only may it fare better when compared to states that have legalised VAD, but it will also provide better evidence on which to review the decision at a future time.

[2] John Keown, 'Voluntary Euthanasia & Physician-Assisted Suicide – The Two "Slippery Slope" Arguments' (The Anscombe Bioethics Centre (Briefing Papers), 2021),
[3] Jones and Paton, 'How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?', 6.

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2. Terminology

2.1 VAD is not adequate terminology to describe what the Bill proposes. Clarity and precision are paramount.[4] VAD, as proposed for NSW, includes both assisted suicide and voluntary euthanasia. This is the case despite the fact that the Bill asserts that VAD should not be understood as 'suicide'.[5] The term VAD conflates assisted suicide and euthanasia, making it difficult to discuss the separate issues they both raise or how this proposal compares with legislation in other jurisdictions.

2.2 The Queensland Law Reform Commission's report of May 2021 rejects the use of the term 'euthanasia' to describe VAD "because of its generality and historic connections to involuntary euthanasia".[6] It remains true, however, that the Bill provides for 'voluntary euthanasia' (in addition to assisted suicide). '*Voluntary* euthanasia' adds specificity and prevents any ambiguity in relation to involuntary euthanasia. Even more specifically, what the NSW Bill describes when referring to "administering practitioners" is, properly speaking, 'voluntary active euthanasia': the administering of lethal drugs to a patient who has requested it, in order to end their life.

2.3 The NSW Bill seeks to distinguish VAD from (non-assisted) 'suicide'. The Queensland Law Reform Commission's report distinguishes VAD from (non-assisted) 'suicide' in two ways. Firstly, that VAD always means medical assistance (that the assistance must come from a medical practitioner). Secondly, that it is "confined to a person who suffers from a condition that will cause death and who experiences suffering that cannot be relieved in a way that the person considers tolerable".[7] This is to distinguish what is ordinarily called 'assisted suicide' from 'non-assisted suicide'.

2.4 The two conditions for distinguishing VAD from 'suicide', whether taken separately or together, do not change the fact that the Bill is referring to suicide (literally: 'the killing of oneself'), and more specifically, 'assisted suicide'. There is overlap between those who die by assisted or non-assisted suicide; many people who die by non-assisted suicide struggle with intolerable suffering and/or have terminal

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[4] David Albert Jones, 'Defining the Terms of the Debate – Euthanasia and Euphemism' (The Anscombe Bioethics Centre (Briefing Papers), 2021), https://www.bioethics.org.uk/images/user/Defining%20the%20Terms%20of%20the%20Debate%20%E2%80%93%20Euthanasia%20and%20Euphemism%20(Prof.%20David%20Albert%20Jones).pdf.
[5] Voluntary Assisted Dying Bill 2021 (NSW), 12 (1).
[6] Queensland Law Reform Commission, *A Legal Framework for Voluntary Assisted Dying: Report 79* (Brisbane: Queensland Law Reform Commission, 2021), para. 1.45.
[7] Ibid., para. 1.46-1.47.

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illnesses. People who die by non-assisted suicide also share many of the concerns or motivations that are stated as reasons for choosing assisted suicide[8] (*e.g.*, "less able to engage in activities making life enjoyable"; "loosing autonomy"; "loss of dignity", "burden on family, friends/caregivers"[9]).

2.5 Canada similarly changed the language regarding assisted suicide and euthanasia (their preferred term being 'medical assistance in dying' MAID). However, it is clear that the practices are equivalent to what in other jurisdictions are called euthanasia and assisted suicide. This is illustrated by the description of the law provided by the Canadian government in February 2017:

> "There are 2 types of medical assistance in dying available to Canadians. They include where a physician or nurse practitioner:
> 1. directly administers a substance that causes death, such as an injection of a drug
>   this is commonly called voluntary euthanasia
> 2. gives or prescribes a drug that is self-administered to cause death
>   this is commonly known as medically-assisted suicide"[10]

Until March 2021 this website continued to acknowledge that these two forms of MAID were also known as voluntary euthanasia and assisted suicide respectively. This is no longer acknowledged overtly but it is clear that the older and more general terminology and the newer and more specifically Canadian terminology denote the same practices.

2.6 It should also be noted that 'assisted dying' is sometimes misinterpreted by the public to mean palliative care—assisting someone through symptom and pain relief as they approach death from their disease. This can give a false perception of greater public support for VAD than is the case.

2.7 In general, it is morally irresponsible to change precise, established terminology to seemingly more benign and diffuse terminology. This is still more problematic in this case because, among other things, it confuses and conflates two practices (voluntary

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[8] Jones, 'Defining the Terms of the Debate – Euthanasia and Euphemism', 5.
[9] Public Health Division, Center for Health Statistics, 'Oregon Death with Dignity Act: 2020 Data Summary', 26 February 2021, 12, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf.
[10] https://web.archive.org/web/20170203015029/https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html

euthanasia and physician-assisted suicide) which have different legal and social consequences. It is important to be able to distinguish between assisted suicide and euthanasia, to highlight the distinct dangers and consequences involved in legislating for each—consequences which will occur whether the language and terminology is used or not.

2.8 Both assisted suicide and euthanasia raise questions of mental capacity. There is an assumption that non-assisted suicide is impulsive and associated with mental illness, and that assisted suicide is something different (clear, reasonable, sustained choice over time). This, however, is a false distinction. Whilst non-assisted suicide may be impulsive and/or the result of mental illness, it is not necessarily so. Some plan their suicide over an extended period and make repeated attempts. It is also the case that some who die by suicide also have chronic or terminal illnesses. In relation to those who die by assisted suicide or euthanasia, while they typically have physical illnesses they may also have mental illness, whether diagnosed or undiagnosed. In at least some cases, then, the person seeking VAD may be suicidal in the uncontroversial sense of the word, and would seek suicide by some other means if VAD were not readily available. In such cases there is no substantial or real difference between the two; fulfilling the requirements of the legislation would be the only factor determining whether the death was or was not deemed to be 'suicide'. In a society that takes suicide prevention seriously, shifting around the definition of suicide is morally irresponsible.

3. Slippery Slope

3.1 There is both theoretical reason and empirical evidence for believing that passing VAD legislation (which would legalise physician-assisted suicide and voluntary active euthanasia) would lead to a 'slippery slope'. This is to say that, in addition to the inherent morality of VAD, if it is introduced certain effects become highly likely and certain changes become ineluctable once it is embraced. This is the case no matter how many safeguards are introduced into proposed legislation, or what language is used. Moreover, legislators must recognise that debating a Bill, such as this one, not only involves scrutinising its specific details, it must also look to future amendments, legal challenges, and wider effects. The consequences, whether intended or unintended, follow by the inner logic of the practice and this can be seen from the experience of other jurisdictions in Europe and North America. It can also be foreseen that future legal challenges or changes to the legislation are already implied in the rationale offered in this legislation.

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3.2 Separating out physician-assisted suicide and voluntary active euthanasia, as needs to be done to properly understand this Bill and its effects, gives rise to two further considerations. Does assisted suicide lead to an increase in non-assisted suicides ('suicide contagion')? (This is dealt with separately below). And does voluntary active euthanasia lead to non-voluntary active euthanasia (administrating of a lethal injection to patients unable to request it)? Furthermore, these developments and effects can be understood from "logical and empirical" arguments.[11]

3.3 In a briefing paper for the Anscombe Bioethics Centre on these two 'slippery slope' arguments, Prof John Keown demonstrates that "one cannot sensibly limit legislation to PAS [physician-assisted suicide] for the 'terminally ill'. The standard moral justifications for such laws are: (i) respect for patient choice and (ii) the duty to relieve suffering. But those are equally arguments for PAS for the *chronically* ill".[12] As the rationale for VAD in the NSW Bill is for the terminally ill, this logical point applies. As the Bill offers voluntary active euthanasia as well, the logical connection between assisted suicide and euthanasia is already acknowledged. For example, it recognises that those who cannot self-administer lethal drugs are likely to request someone else do this, hence the provision for "administering practitioners" in addition to provisions for self-administration.

3.4 Keown argues further that "acceptance of the moral case for VE [voluntary euthanasia] commits one to accepting *non*-voluntary euthanasia or NVE: injections for patients *incapable* of requesting them. The absence of (i) patient autonomy does not cancel (ii) the duty to relieve suffering."[13] Clause 4 of the NSW VAD Bill makes it clear that autonomy (4[b]) is one of the key underlying principles, as is relief of suffering (4[c]). However, if VAD is construed as a beneficial medical treatment then, when autonomous choice is no longer possible, because the person lacks capacity, the doctor's duty to relieve suffering remains. Accepting the moral case for voluntary active euthanasia, there is no reason to deny non-voluntary active euthanasia to those unable to request it ("such as an infant or a person with advanced dementia"[14]).
The importance of the medical practitioner is stressed by those who argue for VE, as Keown points out. A doctor is required to agree that death is in the patient's best interests, indicating the centrality of beneficence even above autonomy: "A responsible doctor would no more agree to kill a patient merely because the patient

[11] Keown, 'The Two "Slippery Slope" Arguments'. See also John Keown, *Euthanasia, Ethics and Public Policy* Cambridge: Cambridge University Press, 2nd ed, 2018.
[12] Ibid., 2.
[13] Ibid.
[14] Ibid., 3.

autonomously requested it than the doctor would prescribe antibiotics or amputate limbs. The doctor, if acting professionally, would decide in each case whether the intervention would truly benefit the patient […]."[15] This rationale leads from VE to NVE if it is deemed in the patient's best interests.

3.5 Following the logical argument there is an empirical 'slippery slope' argument. Keown addresses three principal and overlapping concerns: capacity, depression, and vulnerability.[16] 'Decision-making capacity' (clause 6 of the VAD Bill) is notoriously difficult to determine, and "is a matter of considerable controversy among researchers and clinicians".[17] Similarly, there is an issue with physicians adequately detecting and treating depression, which would be compounded if depression (which is "strongly associated with a desire for a hastened death"[18]) were viewed in the same way as 'suicide' in the VAD Bill: depression if it is found outside of the Bill's eligibility criteria, but reasonable expression of autonomy and desire to end suffering through death if within the criteria. VAD would also place many vulnerable people in a dangerous situation by the psychological pressures and socio-cultural changes of the Bill. People will be under pressure to justify their continued existence once VAD is an option. There is a danger that the "right to die" becomes the "duty to die"[19] due to the major change in relation to life, death, and healthcare. We may also note that the Covid-19 pandemic has placed in the forefront of people's minds the issue of pressuring or burdening the healthcare system. A sense of burden is among the significant reasons why assisted suicide is chosen in Oregon.[20]

3.6 The oppressive effect of this idea is illustrated by a story related by the Australian bioethicist Nicholas Tonti-Filippini who died in 2014 and who suffered from a progressive and incurable illness which might well have qualified him for assistance in suicide under the Voluntary Assisted Dying Bill:

> For several years, until I objected, I received from my health insurer a letter that tells me how much it costs the fund to maintain my health care. I dreaded receiving that letter and the psychological reasoning that would seem to have

[15] Ibid., 4.
[16] Ibid., 6–7.
[17] Ibid., 6 See also Louis C. Charland et al., 'Decision-Making Capacity to Consent to Medical Assistance in Dying for Persons with Mental Disorders' (2016) J Ethics Mental Health 1, 3., as referenced in ibid., 6 n.9.
[18] Ibid.
[19] Lord Sheikh, UK House of Lords, 22 October 2021.
[20] Public Health Division, Center for Health Statistics, 'Oregon Death with Dignity Act: 2020 Data Summary', 12.

> motivated it. Each year I was reminded how much of a burden I am to my community. The fear of being a burden is a major risk to the survival of those who are chronically ill.[21]

3.7 These impact of such legislative proposals on people with disability was also highlighted by the disability activist Jane Campbell in a debate on a similar Bill in the House of Lords only a month ago:

> "It would alter society's view of those in vulnerable circumstances by signalling that assisted suicide is something that they might or ought to consider".
>
> "Disabled people with terminal conditions or progressive conditions like mine are alarmed by the misleading narrative of autonomy and choice".
>
> "We must not abandon those who can benefit from high-quality health and social care to the desperate temptation of assisted suicide in the guise of a compassionate choice."[22]

4. Suicide Contagion

4.1 It is paramount to look at the evidence showing what impact passing VAD legislation (physician-assisted suicide and/or voluntary active euthanasia) has on non-assisted suicide rates. This importantly follows on the necessity for clear terminology; namely, that without correct terms of reference it is harder to follow the evidence on the effect of euthanasia and assisted suicide legislation. Redefining assisted suicide as 'assisted dying' (specifically excluding the language of assisted 'suicide') does not alter the effect of suicide contagion. Does assisted suicide, as is proposed in the NSW Bill, lead to an increase in non-assisted suicides (*i.e.*, what is commonly just referred to as 'suicide')?

4.2 Jones and Paton[23] have produced evidence that introducing assisted suicide is associated with a significant increase in overall self-initiated death, and no reduction in non-assisted suicide. This evidence was set aside by The Report of the Joint Select

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[21] https://www.firstthings.com/web-exclusives/2010/12/our-lives-are-worth-living-an-open-letter-to-the-prime-minister-of-south-australia

[22] Baroness Campbell, UK House of Lords, 22 October 2021.

[23] David Albert Jones and David Paton, 'How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?', *Southern Medical Journal* 108, no. 10 (2015): 6.

Committee on End of Life Choices of Western Australia on the basis that "There is some dispute in the academic literature about the accuracy of Jones and Paton's findings".[24] The Report's authors cite Matthew Lowe and Jocelyn Downie (and a paper by Dembo et al[25] that is wholly dependent on Lowe and Downie) who interpret the data from the United States as showing "no statistically significant association between legalisation of PAS and non-assisted suicide"[26] and the data in European jurisdictions with assisted dying frameworks as indicating that after legalising VAD, "suicide rates either remained the same or fell." However, the paper of Lowe and Downie, which does not appear in PubMed, PsycInfo or other medical citation indices, does not provide any detailed analysis of the data from the US or from Europe. Unlike Jones and Paton, they provide no comparisons with non-PAS/non-EAS states, no statistical analysis of change over time, no control for factors that affect suicide, and no control for state-specific trends. On no measure is the paper of Lowe and Downie as statistically robust as that of Jones and Paton.

4.3 Furthermore, it is not the case that the data analysed by Jones and Paton show that "legalization had no effect"[27] in elevating non-assisted suicide rates. The association between the legalisation of PAS and the rate of non-assisted suicide was found to be positive and significantly so after controlling for state and year effects and factors associated with suicide. The introduction of state-specific trends was a further robustness check to control for bias due to omitted unobservable variables. However, the inclusion of further additional variables can reduce the power of statistical tests to recognise an effect as significant. The available evidence neither demonstrates nor rules out an association between PAS and the increases in non-assisted suicide that have been observed in Oregon, Washington, Montana, and Vermont.

4.4 It should also be noted that there is research on contagion resulting from society's portrayal of end-of-life decisions. The "Werther effect" is suicide contagion resulting from acceptable or positive public portrayals of suicide. The "Papageno effect" is the diminishment of suicide rates due to public portrayals of people coping despite

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[24] A Sanderson and CJ Holt, 'My Life, My Choice: The Report of the Joint Select Committee on End of Life Choices' (West Perth, WA: Parliament of Western Australia, Perth, 23 August 2018), 179.
[25] Justine Dembo, Udo Schuklenk, and Jonathan Reggler, '"For Their Own Good": A Response to Popular Arguments Against Permitting Medical Assistance in Dying (MAID) Where Mental Illness Is the Sole Underlying Condition', *The Canadian Journal of Psychiatry* 63, no. 7 (July 2018): 451–56, https://doi.org/10.1177/0706743718766055.
[26] Matthew P Lowe and Jocelyn Downie, 'Does Legalization of Medical Assistance in Dying Affect Rates of Non-Assisted Suicide?', *Journal of Ethics in Mental Health* 10, no. II. Medical Assistance in Dying (MAID) (May 2017): 5.
[27] Ibid., 4.

suicidal ideation.[28] In a society that takes suicide prevention seriously, it is important that legislation does not cause a change in attitude to suicide. Removing the term 'suicide' from the legislation does not affect the public perception; the legislation determines and gives approval to the view that a stage can be reached when life is no longer considered worth living. Suicide prevention necessarily requires that a society reinforce positive messages about life in the face of suffering, and not seeking death as a solution. However much the autonomy of the individual requesting VAD is stressed, there is an inevitable social impact which changes people's views about life and death.

5. Conscientious Objection

5.1 A final note on conscientious objection.[29] It should be noted that an increasing expectation, in law and socially, is for the conscientious objector to be forced to make an effective and timely referral of a patient to a physician who will provide the requested procedure. An example from the UK shows how conscientious objection law can be weakened in this way by the courts.[30] However, morally speaking, *the act of referring someone for a procedure in order to ensure that it happens is direct or formal cooperation.* This is easier to see from examples.

> "A doctor might, for example, conscientiously object to infant male circumcision, to conversion therapy (in jurisdictions where this is legal), to skin whitening or to disabling surgery such as elective amputation. It would be contrary to that individual doctor's judgement of good patient care to arrange "effective and timely referral" to a practitioner who would provide the service. Again, if a doctor objects in conscience to participation in torture or capital punishment or to force feeding of a prisoner who is on hunger strike, it would be unprincipled for them to find someone with fewer scruples to do the deed for them. To require a conscientious objector to facilitate delivery of the

[28] Jan Domaradzki, 'The Werther Effect, the Papageno Effect or No Effect? A Literature Review', *International Journal of Environmental Research and Public Health* 18, no. 5 (1 March 2021): 2396, https://doi.org/10.3390/ijerph18052396; Andreas Frei et al., 'The Werther Effect and Assisted Suicide', *Suicide and Life-Threatening Behavior* 33, no. 2 (June 2003): 192–200, https://doi.org/10.1521/suli.33.2.192.22768; Aaron Kheriaty, 'Social Contagion Effects of Physician-Assisted Suicide: Commentary on "'How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?"'", *Southern Medical Journal* 108, no. 10 (October 2015): 605–6.

[29] See also Christina Lamb, 'Conscientious Objection: Understanding the Right of Conscience in Health and Healthcare Practice', *The New Bioethics* 22, no. 1 (2 January 2016): 33–44, https://doi.org/10.1080/20502877.2016.1151252.

[30] Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland) (UKSC 17 December 2014).

> procedure to which they object is a direct attack on person's conscience and moral integrity, and thus a serious harm to them. It would be much better to say nothing about conscientious objection than to undermine it by imposing a requirement for "effective and timely referral".[31]

5.2 As the VAD Bill does not include any protection against being forced to refer and as the Bill requires the provision of information on how to obtain VAD, it seems likely that they will be vulnerable in the future to a requirement to refer.

5.3 A conscience clause should also include institutional conscience, that is to say, the freedom of organisations to maintain an ethos that excludes certain practice. The Bill gives limited rights for residential and care facilities not to participate in VAD, but again the definition of participation is circumscribed. They will be required to make information available. They will be required to allow third parties to access the institution for the purpose of facilitating VAD. They will not be able to sanction staff who wish to participate in VAD. Though, under certain circumstances the institution may facilitate the transfer of the person seeking VAD to another institution it seems that the non-participating institution must identify the other institutions that would participate. Hence it would require close cooperation even if the final act would not happen within the institution. Indeed, given that the institution has no ability to prevent the administration of a lethal substance on its premises it is not clear what is to be gained by such transfer.

5.4 Even if the individual and institutional conscience clauses in the Bill were improved, the experience of other jurisdictions is that after a law is passed there is progressively less tolerance of the views of those who object. In political terms, a conscience clause is a means to mollify those with concerns about legislation so that it passes with the minimum of opposition. However, once a Bill has passed into law and become established the clause has served its political purpose. From that moment conscience protections are construed only as obstacles to provision of a legal service and are progressively weakened by restrictive interpretation. Once the fundamental protection of life and of professional ethical standards enshrined in current law are breached by the acceptance of VAD, it would be naïve to think that a conscience clause and other supposed safeguards will protect patients from abuse or professionals from coercion. This is not the experience of other nations.

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[31] The Anscombe Bioethics Centre Submission to the World Medical Association Public Consultation on a draft devised version of the International Code of Medical Ethics (25 May 2021) https://www.consciencelaws.org/ethics/ethics061.aspx

6. I have given evidence over 80 times to parliamentary and professional bodies on a variety of bioethical topics including end of life care.[32] On request from the committee I would be available and would be more than happy to provide oral testimony to the inquiry at one of its public hearings.

Professor David Albert Jones

22 November 2021

[32] Including being one of three academics providing oversight and content advise for the Jersey Citizen's Jury on Assisted Dying (2021); Submission to the Committee on Justice on the Dying with Dignity Bill 2020 [Ireland], (2021); Oral evidence and submission to the New Zealand Parliamentary Justice Committee on the End of Life Choice Bill (2018); Oral and written evidence to the New Zealand Health Select Committee Investigation into Ending One's Life (2016/2017); Submission to the External Panel on Options for a Legislative Response to Carter v Canada (2015); Response to NICE consultation on Care of the Dying Adult (2015); Oral and written evidence to the Health and Sport Committee in relation to the Assisted Suicide (Scotland) Bill (2014/2015); Response to a House of Commons Select Committee enquiry on end of life care (2014); Oral and written evidence to a UK Ministry of Justice enquiry into the level of evidence coroners require before reaching a conclusion of suicide (2014); Response to Consultation on Margo McDonald Assisted Suicide Bill (2014); Response to the Assisted Suicide (Scotland) Consultation (2012); Letter to Lord Falconer 'Commission on Assisted Dying' (2011).

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