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Assisted Dying for Terminally Ill Adults (Scotland) Bill

Submission by
DIGNITAS – To live with dignity – To die with dignity
Forch, Switzerland

for and on behalf of the 105 Scottish and 1,392 UK members of DIGNITAS
submitted in electronic format to Liam.McArthur.msp@parliament.scot

Contents of this submission page

1) Introduction

This submission comments on some issues in the consultation document for the Assisted Dying for Terminally Ill Adults (Scotland) Bill[1] provided by Liam McArthur, Member of the Scottish Parliament. It provides information for the discussion on introducing assisted dying legislation in Scotland. It does not claim to, and it cannot cover the issue in all details.

The Swiss non-profit membership association "DIGNITAS – To live with dignity – To die with dignity" (hereafter abbreviated "DIGNITAS" for easier reading) provides this submission based on its work of 23 years. Amongst other fields, this includes further developing human rights in the field of choice in quality of life and end-of-life issues, as well as know-how and experience from conducting over 3,200 assisted/accompanied suicides (PSAS)[2] in line with Swiss law. The reason for providing this submission is obvious from the aims and further information available on the website of DIGNITAS[3].

DIGNITAS finds that the proposed Assisted Dying for the Terminally Ill Adults (Scotland) Bill is an important step forward to resolve several problems of the present legal situation in Scotland which, in regard of assisted dying, is now inadequate and incoherent, as it (still) is all over the UK[4], despite a first concrete parliamentary decision on the Island of Jersey[5]. Therefore, in answer to the first question in the section "Your views on the proposal", the "Aim and approach" of the proposed Bill, DIGNITAS is fully supportive despite raising criticism in some points as explained hereafter.

DIGNITAS is happy to give further evidence, personal, oral and written, if Liam McArthur and others involved in the consultation would wish so, as DIGNITAS already did in the consultation process for an Assisted Suicide Scotland Bill (SP Bill 40) of the late MSP Margo MacDonald. They are also welcome to visit DIGNITAS.

2) Assisted Dying: a matter of human right, freedom and choice

All European states – with the exception of the Vatican, Belarus and Kosovo – have adhered to the European Convention on Human Rights (ECHR)[6]. In specific cases, set legal situations may be questioned whether they would be in line with the basic human rights and liberties enshrined in the ECHR. The European Court of Human Rights (ECtHR)[7] has developed an important jurisdiction on basic human rights, including the issue of the right to choose a voluntary death. According to its preamble, this international treaty is not only a fixed instrument, "securing the universal and effective recognition and observance of the rights therein declared" but also aiming at "the achievement of greater unity between its members and that one of the methods by which that aim is to be pursued is the maintenance and further realisation of human rights and fundamental freedoms"[8]. The ECHR text and case law are relevant

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1 https://www.parliament.scot/bills-and-laws/bills/proposals-for-bills/proposed-assisted-dying-for-terminally-ill-adults-scotland-bill
2 See subheading 4) "terms and abbreviations used in this submission".
3 E.g. "The basic information at a glance and a 'click" on http://www.dignitas.ch/index.php?lang=en
4 See the report by The Commission on Assisted Dying https://www.demos.co.uk/files/476_CoAD_FinalReport_158x240_I_web_single-NEW_.pdf?1328113363
5 https://www.facebook.com/dignitas.ch/posts/2988197874779730?__tn__=-R
6 The Convention: http://www.echr.coe.int/Documents/Convention_ENG.pdf ; Member States: http://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/005/signatures
7 https://www.echr.coe.int
8 http://www.echr.coe.int/Documents/Convention_ENG.pdf page 5.

in discussing an assisted dying bill for Scotland[9], which is why DIGNITAS herewith outlines aspects of a selection of the ECtHR judgments, besides further court judgments in relation to a self-determined and self-enacted end of suffering and life.

In the judgment of the ECtHR in the case of DIANE PRETTY v. the United Kingdom dated 29 April 2002[10], at the end of paragraph 61, the Court expressed:

> "Although no previous case has established as such any right to self-determination as being contained in Article 8 of the Convention, the Court considers that the notion of personal autonomy is an important principle underlying the interpretation of its guarantees."

Furthermore, in paragraph 65 of this judgment, the Court expressed:

> "The very essence of the Convention is respect for human dignity and human freedom. Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity."

On 3 November 2006, the Swiss Federal Supreme Court recognized that someone's decision to determine the way of ending his/her life is part of the right to self-determination protected by article 8 § 1 of the ECHR, stating:

> "The right to self-determination within the meaning of Article 8 § 1 [of the Convention] includes the right of an individual to decide at what point and in what manner he or she will die, at least where he or she is capable of freely reaching a decision in that respect and of acting accordingly."[11]

In that decision, the Swiss Federal Supreme Court had to deal with the case of a man suffering not from a physical but a psychiatric/mental ailment. It further recognized:

> "It must not be forgotten that a serious, incurable and chronic mental illness may, in the same way as a somatic illness, cause suffering such that, over time, the patient concludes that his or her life is no longer worth living. The most recent ethical, legal and medical opinions indicate that in such cases also the prescription of sodium pentobarbital is not necessarily precluded or to be excluded on the ground that it would represent a breach of the doctor's duty of care. […] Where the wish to die is based on an autonomous and all-embracing decision, it is not prohibited to prescribe sodium pentobarbital to a person suffering from a psychiatric illness and, consequently, to assist him or her in committing suicide." […] The question of whether the conditions have been met in a given case cannot be examined without recourse to specialised medical – and particularly psychiatric – knowledge, which is difficult in practice; a thorough psychiatric examination thus becomes necessary…"

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9 Something the consultation document acknowledges.
10 Application no. 2346/02; Judgment of a Chamber of the Fourth Section: http://hudoc.echr.coe.int/eng?i=001-60448
11 BGE 133 I 58, page 67, consideration 6.1 (translated): http://bit.ly/BGE133I58

Based on this judgment, the applicant made efforts to obtain an appropriate assessment, writing to 170 psychiatrists – yet he failed to succeed. Seeing that the Swiss Federal Supreme Court had obviously set up a condition which in practice could not be fulfilled, he took the issue to the ECtHR.

On 20 January 2011, the ECtHR rendered the judgement HAAS v. Switzerland[12] and stated in paragraph 51:

> "In the light of this case-law, the Court considers that an individual's right to decide by what means and at what point his or her life will end, provided he or she is capable of freely reaching a decision on this question and acting in consequence, is one of the aspects of the right to respect for private life within the meaning of Article 8 of the Convention."

In this, the ECtHR adhered to the Swiss Federal Supreme Court and acknowledged that the freedom to choose the time and manner of one's own end in life is a basic human right protected by the ECHR.

In a further case, ULRICH KOCH against Germany, the applicant's wife, suffering from total quadriplegia after an accident, demanded that she should have been granted authorisation to obtain 15 grams of pentobarbital of sodium, a lethal dose of medication that would have enabled her to end her ordeal by choosing suicide at her home. In its decision of 19 July 2012, the ECtHR declared the applicant's complaint about a violation of his wife's Convention rights inadmissible, however, the Court held that there had been a violation of Article 8 of the Convention in that the [German] domestic courts had refused to examine the merits of the applicant's own rights he claimed[13]. The case had to be dealt with by the German domestic courts again. Finally, the German Federal Administrative Court corrected the lower courts judgments: The general right to personality article 2,1 (right to life) in connection with article 1,1 (protection of human dignity) of the Basic (Constitutional) Law of Germany comprises the right of a severely and incurably ill patient to decide how and at what time his or her life shall end, provided that he or she is in a position to make up his or her own mind in that respect and act accordingly. The Court found, even though it was generally not possible to allow the purchase of a narcotic substance for the purpose of suicide, there had to be exceptions[14].

In the case of GROSS v. Switzerland, the ECtHR further developed its jurisdiction. The case concerned a Swiss woman born in 1931, who, for many years, had expressed the wish to end her life, as she felt that she was becoming increasingly frail, and she was unwilling to continue suffering the decline of her physical and mental faculties. After a failed suicide attempt followed by inpatient treatment for six months in a psychiatric hospital which did not alter her wish to die, she tried to obtain a prescription for sodium pentobarbital by Swiss medical practitioners. However, they all rejected her wish; one felt prevented by the Swiss code of professional medical conduct as the woman was not suffering from any life-threatening illness,

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[12] Application no. 31322/07; Judgment of a Chamber of the First Section: http://hudoc.echr.coe.int/eng?i=001-102940
[13] Application no. 479/09, Judgment of the Former Fifth Section: http://hudoc.echr.coe.int/eng?i=001-105112
[14] See the respective press release by DIGNITAS http://www.dignitas.ch/images/stories/pdf/medienmitteilung-08032017.pdf (in English); link to the judgment by the Federal Administrative Court of Germany: http://www.bverwg.de/entscheidungen/entscheidung.php?ent=020317U3C19.15.0 (in German).

another was afraid of being drawn into lengthy judicial proceedings. Attempts by the applicant to obtain the medication to end her life from the Health Board were also to no avail.

In its judgment of 14 May 2013[15], the ECtHR held in paragraph 66:

> "The Court considers that the uncertainty as to the outcome of her request in a situation concerning a particularly important aspect of her life must have caused the applicant a considerable degree of anguish. The Court concludes that the applicant must have found herself in a state of anguish and uncertainty regarding the extent of her right to end her life which would not have occurred if there had been clear, State-approved guidelines defining the circumstances under which medical practitioners are authorised to issue the requested prescription in cases where an individual has come to a serious decision, in the exercise of his or her free will, to end his or her life, but where death is not imminent as a result of a specific medical condition. The Court acknowledges that there may be difficulties in finding the necessary political consensus on such controversial questions with a profound ethical and moral impact. However, these difficulties are inherent in any democratic process and cannot absolve the authorities from fulfilling their task therein."

In conclusion, the Court held that Swiss law, while providing the possibility of obtaining a lethal dose of sodium pentobarbital on medical prescription, did not provide sufficient guidelines ensuring clarity as to the extent of this right and that there had been a violation of article 8 of the Convention. However, the case was referred to the Grand Chamber of the ECtHR by the Swiss government as, prior to a public hearing on the case, it became known that the applicant had passed away in the meantime. This led to the case not being pursued.

Another important judgment was rendered on 26 February 2020 by the Federal Constitutional Court of Germany[16]: The court declared unconstitutional and void § 217 of the German Criminal Code ("geschäftsmässige Förderung der Selbsttötung"), a statuary provision that had criminalised repeated – and thus professional – advisory work and assistance for a self-determined ending of one's own life[17]. The Court held:

> "The general right of personality (Art. 2(1) in conjunction with Art. 1(1) of the Basic Law, (Grundgesetz – GG) encompasses a right to a self-determined death. This right includes the freedom to take one's own life and, as the case may be, resort to assistance provided voluntarily by third parties for this purpose. […] The right to a self-determined death is not limited to situations defined by external causes like serious or incurable illnesses, nor does it only apply in certain stages of life or illness. Rather, this right is guaranteed in all stages of a person's existence. Restricting the scope of protection to specific causes or motives would essentially amount to a substantive evaluation, and thereby predetermination, of the motives of the person seeking to end their own life, which is alien to the Basic Law's notion of freedom. The individual's decision to end their own life, based on how they personally define quality of life and a meaningful existence, eludes any evaluation on the basis of general values, religious dogmas, societal norms for dealing with life and death, or considerations of objective rationality. It

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[15] Application no. 67810/10; Judgment of a Chamber of the Second Section: http://hudoc.echr.coe.int/eng?i=001-119703

[16] https://www.bundesverfassungsgericht.de/SharedDocs/Entscheidungen/EN/2020/02/20rs20200226_2bvr234715en.html;jsessionid=F8EFC14823BD3416540D99532198F136.1_cid354

[17] See: http://www.dignitas.ch/images/stories/pdf/medienmitteilung-26022020-e.pdf

> is thus not incumbent upon the individual to further explain or justify their decision; rather, their decision must, in principle, be respected by state and society as an act of autonomous self-determination."

On 11 December 2020, the Austrian Constitutional Court[18] rendered its judgment on a constitutional complaint against the prohibition of assistance in suicide and voluntary euthanasia. § 78 "participation in self-murder" (sic!) of the Austrian criminal code, which was set up in the Austro-fascist 1930s, said: "Any person who incites another to commit suicide [literally: "kill himself"], or provides help in this, is liable to a custodial sentence of six months to five years." The Court found the second fact of § 78 („or provides help in this") unconstitutional, with effect from 1 January 2022. In essence the Court held:

> "A right to free self-determination is to be derived from several constitutional guarantees, in particular the right to private life, the right to life, as well as the principle of equality. This right also extends to the freedom to end one's own life. Where a person decides to end his or her own life, this decision must be respected by the State provided that it is based on the free will of the individual concerned. The right to end one's own life also includes the freedom to seek and, where offered, make use of assistance provided by third parties for that purpose. […] From a fundamental rights perspective there is no difference between a patient that refuses life-prolonging or life-maintaining medical measures within his or her sovereignty over treatment or by exercising his or her right to self-determination within his or her living will, and a person willing to commit assisted suicide as part of his or her right to self-determination in order to die in dignity. In both cases, the decisive aspect is that the decision is taken on the basis of free self-determination"

In this context the so-called ARTICO-jurisdiction based on the ECtHR judgment of 13 May 1980, series A no. 37, no. 6694/74, paragraph 33[19] needs to be remembered:

> "The Court recalls that the Convention is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective; . . ."

Dignity and freedom of humans mainly consists of acknowledging the right and freedom of someone who does not lack capacity to decide even on existential questions for him- or herself, without outside interference. Everything else would be paternalism compromising dignity and freedom of choice. In the judgment PRETTY v. the United Kingdom mentioned before, the Court correctly recognized that this issue will present itself increasingly – not only within the Convention's jurisdiction, but internationally – due to demographic developments and progress of medical science.

3) Comments on some points in the consultation document

Re 1 "terminally ill"

To only allow access to assisted dying for individuals who are terminally ill (as defined in the consultation document) is to discriminate against individuals who suffer from health conditions that are, by medical opinion, not "progressive" and "reasonably expected to cause

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[18] Abstract in English provided by the Court: https://www.vfgh.gv.at/downloads/Bulletin_2020_3_AUT-2020-3-004_G_139_2019.pdf ; respective press release by DIGNITAS: http://www.dignitas.ch/images/stories/pdf/medienmitteilung-11122020-e.pdf

[19] http://hudoc.echr.coe.int/eng?i=001-57424

death". For example, individuals such as the late PAUL LAMB, who was paralysed from the neck downwards after an accident, and who fought in the UK courts to obtain access to assisted dying[20]. Furthermore, individuals with severe psychiatric ailments are discriminated against – whilst in fact the very claimant before the ECtHR Mr. HAAS, who brought about the judgment acknowledging the human right/freedom to decide on time and manner of one's own end in life, was suffering from a psychiatric ailment and not a physical terminal disease[21].

Making use of any form of assisted dying – whether by PSAS or voluntary euthanasia or discontinuing treatment / "passive euthanasia" (e.g. based on a legally effective advance directive) – is a personal choice in the frame of every individual's right to self-determination; no matter whether (or not) such individual is in fact or assumed to be a member of a certain social group, majority or minority.

DIGNITAS suggests that the proposed Bill adopts eligibility criteria that do not give precedence to what some doctors judge about suffering of their patient, but rather to focus on the personal experience / point of view of the individual/patient, such as is, for example, set out in the medical-ethical guidelines "Management of dying and death" published 2018 by the Swiss Academy of Medical Science (ASSM), the relevant criteria being: "The symptoms of disease and/or functional impairments are a source of intolerable suffering for the patient"[22].

Besides, permitting access to assisted dying for only the terminally ill appears illogical in the light of the fact that life itself is a "diagnosis" that is "reasonably expected to cause death", whether or not a medical practitioner diagnoses a condition that is progressive and estimates a certain life expectancy.

Re 1.1 Safeguards

Re "Two doctors"

Whilst DIGNITAS acknowledges that involving two separate doctors in the process of assessing and possibly supporting an individual's request for assisted dying may be seen as a safeguard, it adds an unnecessary hurdle that consumes time which a rapidly declining individual may have little left of, and it prolongs the suffering. In the Swiss legal system of PSAS, one doctor is seen as sufficient[23]. This doctor may choose to reach out to one or several colleagues if, for example, the individual's situation and request for assisted dying appears complex and the doctor wishes for support and second opinion(s). In Switzerland this has proved to work well for 35 years, and DIGNITAS suggests changing the proposed Bill in this point.

In the analysis and discussion following the consultation period, the question should be discussed whether *at all* doctors should be involved as "gatekeepers" for assisted dying. In the light of the human rights and constitutional court judgments mentioned in subheading 2 of this submission, it can be noted that the prerequisite of a medical condition, even more so one that is diagnosed as being progressive and causing death as foreseen in the proposed Bill, violates the very human right to decide on the time and manner of one's own end in life (and

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[20] The case of Paul Lamb (and Tony Nicklinson) was finally referred to the ECtHR, yet the ECtHR declared LAMB's complaint inadmissible because the rule of exhaustion of domestic remedies had not been observed. https://hudoc.echr.coe.int/eng?i=001-156476

[21] Case of HAAS v. Switzerland, application no. 31322/07, https://hudoc.echr.coe.int/eng?i=001-102940 ; see also subheading 2) "Assisted Dying: a matter of human right, freedom and choice" in this submission.

[22] https://www.samw.ch/dam/jcr:25f44f69-a679-45a0-9b34-5926b848924c/guidelines_sams_dying_and_death.pdf , page 23.

[23] See pages 11, 13 and 31 herein: http://www.dignitas.ch/images/stories/pdf/diginpublic/referat-cssb-26112021.pdf

for this to reach out to voluntary help from others). A different assessment procedure should be discussed, in which doctors do not (need to) pass judgement on whether or not someone has a medical diagnosis, whether or not it is progressive and whether or not this is expected to cause death. Rather, they should put centre stage what the individual considers to be quality of life. The role of doctors would then be to focus on establishing that the individual requesting assisted dying:

- understands the information relevant to the decision relating to access to assisted dying and the effect of the decision; and
- has reached a voluntary decision without coercion or duress; and
- is informed as to palliative, hospice and other care options – this should include information as to the potential negative effects of unguided DIY-suicides; and
- is able to communicate the decision and their views and needs as to the decision in some way, including by speech, gestures or other means, and also able to administer the life-ending medication themselves; and
- has discussed the matter with their loved ones with the aim of avoiding a "negative surprise effect and impact" for these loved ones.

This approach would also alleviate any pressure that doctors may feel about making predictions such as "reasonably expected to cause death".

Re "Two doctors establish that the person has the mental capacity to request an assisted death."

It needs to be remembered that, in principle, people who are of age (in Scotland: 16) are assumed to be mentally competent unless there are indications that their mental capacity is limited or no longer present. This is the basis in common law which recognises – as a "long cherished" right – that all adults must be presumed to have capacity until the contrary is proved[24]. An indication that mental competence might not be given is the situation that the person is suffering from a serious psychiatric illness. However, a psychiatric illness may impact a person's mental capacity, but it need not. Sometimes it is observed, especially amongst opponents of assisted dying working in the fields of psychiatry and psychology, that it is insinuated that individuals requesting assisted dying would up-front potentially not have capacity. This approach not only tries to turn upside down the legal basis but it labels and stigmatises people who contemplate end-of-life choices – with the negative effects of entrenching the taboo on suicide, (assisted) dying and death, and risking these people potentially not talking to doctors, therapists and their loved ones but "taking matters in their own hands"[25].

Re "A suggested waiting period of 14 days allows the person time to reflect on their decision. This timeframe is shorter if the person is expected to die within 30 days."

DIGNITAS suggests that in both situations there should be no waiting period. The experience of DIGNITAS derived from having conducted over 3,200 PSAS is that, generally, people who contemplate end-of-life-choices make up their mind as part of their "personal life

[24] This approach is also found, for example, in the Voluntary Assisted Dying Act 2017 of Victoria, Australia: "…a person is presumed to have decision-making capacity unless there is evidence to the contrary." https://www.legislation.vic.gov.au/in-force/acts/voluntary-assisted-dying-act-2017/003 . Also Swiss law bases on the assumption that everybody is assumed to have capacity of judgment; this, unless there are clear signs that such is not the case, see article 16 of the Swiss Civil Code https://www.admin.ch/opc/en/classified-compilation/19070042/index.html#a16

[25] See the TEDx talk "Cracking the taboo on suicide is the best means to prevent suicide attempts and deaths by suicide" http://www.dignitas.ch/images/stories/pdf/diginpublic/referat-tedxzurich-08072021.pdf

philosophy" long before they would face a health situation in which they would get in touch with DIGNITAS to request PSAS[26]. Any time frame – 30, 14 days, or shorter – leads to possibly prolonging the suffering. The assessment procedure as foreseen in the proposed Bill already takes time. Furthermore, a criterion "expected to die within 30 days" appears arbitrary and hypothetic: is there any doctor or anyone else who is able to predict the future, able to predict with certainty whether or not someone will be alive in 30 or any other number of days? In the Swiss legal system of PSAS[27] there is no such mandatory waiting period and it does not appear to have posed a problem in 35 years of this being practice.

Re 2.2 Consequences of the current position, page 10: "…as his organisation and others are oversubscribed and overburdened by terminally ill people travelling abroad, due to the lack of assistance to die in their own country."

There appears to be a misunderstanding which needs to be clarified: The non-profit membership association DIGNITAS is not oversubscribed or overburdened due to individuals from outside of Switzerland, whether that is residents of Scotland or other countries, travelling to DIGNITAS for PSAS. In fact, DIGNITAS can handle more requests for assisted dying. However, this is not the aim of DIGNITAS. In over 23 years of operation, DIGNITAS has, besides other work, focussed on implementing the human right of individuals to decide on time and manner of their own end in life and to have access to professional help to put this into practice in a legal and safe way at their home. DIGNITAS does this so that these individuals (and their loved ones) do not have to carry the burden of going abroad with all the negative consequences thereof. Alongside this, DIGNITAS and the country of Switzerland would not then have to take care of an issue which should be resolved by the states that these individuals travel from. The aim of DIGNITAS is that the "medical tourism of assisted dying" stops and DIGNITAS becomes obsolete for these people[28]. DIGNITAS will serve as an information provider and "emergency exit" only as long as many countries' governments and legal systems disrespect their citizens' basic human right to self- determination and choice in life and life's end, ban the topic with a taboo, and force them either to turn to lonely risky suicide attempts or to travel abroad instead.

Re 2.5 Protecting vulnerable people

"The safeguards outlined at section 1.1 would act to ensure that vulnerable people are not adversely affected"

It should be noted that the argument of protecting vulnerable people can have a stigmatising pretext side to it. Not every individual who may be seen by third parties as vulnerable would personally share this view. One needs to bear in mind that there is a fine line where well-meant protection turns into undesired paternalism. Such paternalism very much applies to psychiatry, which has a long-standing view that a desire to die is a manifestation of mental illness, whilst in fact patients who secure and utilise a lethal prescription are generally exercising an autonomous choice unencumbered by clinical depression or other forms of incapacitating mental illness[29].

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[26] See also page 16 in the consultation document, footnotes 70 and 71.
[27] See pages 11, 13 and 31 herein: http://www.dignitas.ch/images/stories/pdf/diginpublic/referat-cssb-26112021.pdf
[28] See "The goal of DIGNITAS", page 19 herein: http://www.dignitas.ch/images/stories/pdf/diginpublic/referat-cssb-26112021.pdf
[29] Cambridge Quarterly of Healthcare Ethics 2014, http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=9333247&fileId=S0963180114000085

Whilst in principle DIGNITAS agrees with the notion of protection of any individual (not only "vulnerable") who does not wish to get involved with assisted dying, and there is a duty to protect life as enshrined in article 2 ECHR, one needs to aim for an assisted dying law which is, as pointed out earlier in this submission, practical and effective and not merely theoretical or even illusionary[30]. Only wide eligibility criteria will resolve the undesirable negative consequence that people travel to DIGNITAS or choose unguided risky DIY-suicides.

"Only a minority of cases are investigated when someone travels overseas for an assisted death."

It should be noted that under Swiss law, every case of PSAS must be reported to the police which leads to an investigation involving the state prosecution service, the police and an official doctor (the latter presumably similar to a member of the Scottish Fatalities Investigation Unit). Only if the state prosecution service is satisfied that there was no violation of the law, but that it was a legal PSAS, the case will be cleared.

"The fact that assisted dying overseas is tolerated without clear regulation…"

Indeed. For many years, the UK has been outsourcing the issue of assisted dying to Switzerland, thus knowingly violating citizens' human right to have this choice at home, but so far failed to legislate outright for its own citizens despite the fact that a clear majority of the public has been requesting for this for many years. With this, close to 500 UK residents, including 16 of Scotland, have been forced to leave their home just because they wished to have legal assisted dying, which they were able to access at DIGNITAS.[31]

Re 4.1 Equalities – Disability – "The first is the overarching and simplest safeguard: people would not qualify under this proposal's criteria by having a disability alone."

As already indicated earlier in this submission, prohibiting access to assisted dying on the grounds of the individual being part of a certain group, especially a minority group, constitutes a discrimination against such an individual and group. This applies to individuals having a disability. Those denied access to and help in assisted dying are left to illegal and/or risky approaches and methods, for example, unguided DIY-suicide of which the majority fail with dire consequences for the individual, their loved ones and society in general[32]. Not permitting access can violate the human right to life and constitute an inhumane or degrading treatment. Both are aspects of the ECHR.

Re 4.2 Sustainability – footnote 121: "It should be noted that the organisations providing this assistance operate as not for profit and do, on occasion, support people with fee waivers etc."

DIGNITAS would like to clarify this: every member of DIGNITAS living in modest economic circumstances can apply for, and will be granted, a reduction or even exemption from having

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[30] In the sense of the ARTICO-jurisdiction of the ECtHR (case of ARTICO v. Italy, judgment of 13th May 1980, paragraph 33, https://hudoc.echr.coe.int/eng?i=001-57424).

[31] As per date of this submission; the statistic on DIGNITAS' website is per end of year and will be updated soon, this also applies to the number of signed-up members of DIGNITAS; http://www.dignitas.ch/index.php?option=com_content&view=article&id=32&Itemid=72&lang=en

[32] See also page 13, subheading 7) "The protection of life and the general problem of suicide" in DIGNITAS' submission to the Joint Committee on End of Life Choices South Australia: http://www.dignitas.ch/images/stories/pdf/diginpublic/stellungnahme-submission-end-of-life-choices-south-australia-31072019.pdf

to pay membership fees. This includes membership subscription just as much as fees related to preparing and conducting PSAS. This is pointed out in DIGNITAS' information brochure and the articles of association, published on the website of DIGNITAS. However, even if DIGNITAS does not charge any fees, that does not change any of the negative consequences of Scottish residents not having the choice of assisted dying at home.

4) Terms and abbreviations used in this submission

Assisted dying: an umbrella term including PSAS and/or voluntary euthanasia with the support of and/or carried out by doctors/physicians. In this submission, depending on the context, it is used as defined in the consultation document.

Assisted / accompanied suicide / physician-supported accompanied suicide (abbreviation: **PSAS**): this is what is made possible for members of DIGNITAS in the frame of Swiss law. A person wishing to put an end to their suffering and their life chooses a well-considered, carefully prepared self-administration of a lethal substance provided by a (Swiss) physician usually at their home. The physician has assessed the person's request and medical file, the person is accompanied by professionals all through the process until the end, and next-of-kin and friends are involved.

Voluntary euthanasia: a person wishing to end his/her own life requests and permits a third person to put an end to his/her life, for example by injection of a lethal medication. This is prohibited in Switzerland, yet legal under certain circumstances in some countries such as Belgium, Luxembourg and The Netherlands.

Passive euthanasia: (termination of treatment, "to let die"): ending or not starting life-maintaining and life-prolonging therapies, renouncing treatments, waiving food and drink.

Palliative care: an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (as defined by the World Health Organisation WHO).

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This response to the consultation is submitted by e-mail. We confirm that we have read and understood the Privacy Notice set out in the consultation document. This submission may be entered into Smart Survey by Liam McArthur's office or NGBU if they choose so.

Yours sincerely,
DIGNITAS
To live with dignity - To die with dignity

Ludwig A. Minelli Silvan Luley