Philosophers' Consortium on Assisted Dying in Scotland

PCADS Policy Paper: Coercion and Assisted Dying Laws

Private Members' Bills are currently under consideration at the Scottish Parliament, and at the UK Parliament in Westminster, to allow assisted dying for people who are terminally ill, if they are psychologically competent and request it. Some people oppose legalization because of fears that the legal availability of this option will make people vulnerable to coercion: people who might not otherwise die, and who wouldn't otherwise want to die, might choose an assisted death as the result of external pressure from medical professionals or family members. This policy briefing evaluates the evidence for those fears, and summarises relevant ethical research on coercion. It concludes that concerns about coercion are not borne out by the evidence. Risks to patients at the end of their lives are better balanced through appropriate legalisation.

This conclusion is supported by four key findings:

1. There is no evidence of people being coerced into choosing to die in jurisdictions where assisted dying has been legalised;
2. This lack of evidence is unsurprising, because medical professionals already possess knowledge and protocols to satisfactorily address risks of coercion at the end of life;
3. In evaluating the risks of assisted dying legislation, the known risks of preventing lawful assisted dying must also be given due consideration;
4. The legalization of assisted dying opens the practice up to legal and regulatory scrutiny that reduces the risk of coercion.

1. There is no evidence of people being coerced into choosing to die in jurisdictions where assisted dying has been legalised.

Coercion was a key point of investigation for committee inquiries in both Holyrood and Westminster. The results of both inquiries are clear: there is no evidence that people are coerced into assisted dying where it is legal.

Experts report as much from a wide range of jurisdictions, including all the places that are models for legislation proposed for the UK. Dr Ryan Spielvogel testified in Westminster that 'in the 25 years that aid in dying has been legal in jurisdictions in the United States, there has never been a single substantiated claim of coercion [into choosing assisted dying]'.[1]

[1] committees.parliament.uk/writtenevidence/114567/pdf/

Dr Alison Payne wrote to the Holyrood committee that 'I have not yet seen evidence of coercion [in New Zealand] – more often the family are reluctant for it to happen'.[2] Julian Gardner, the chair of the Australian state of Victoria's Voluntary Assisted Dying Review Board, said that

> … we have not had any reports of that nature in Victoria in the five years in which the system has been in place. The only reports that we have had have been the reverse, in that people have experienced coercion—that might be too strong a word—or undue influence *not to go ahead with ending their life*, generally from relatives who have objections or from faith-based institutions.[3]

Similar evidence was given by UK-based researchers, summarising all empirical studies which bear upon the question. Professor Nancy Preston, Professor of Supportive and Palliative Care at the University of Lancaster, said: 'We have no evidence to support that [coercion into choosing assisted dying] would happen … I do not think there is any evidence of coercion.'[4] Dr Alexandra Mullock, Senior Lecturer in Healthcare Law at the University of Manchester, said: 'there is no evidence [of coercion]'.[5] Dr Naomi Richards, Director of the Glasgow End of Life Studies Group at the University of Glasgow, replied to a question about evidence of pressure on people who have chosen assisted death, saying that '[t]here is none that they have been coerced'.[6]

This negative result is striking, especially given the prominence that fears about coercion have for campaigners against assisted dying laws,[7] and for parliamentarians considering the issue.[8] In neither inquiry, nor in any published research, has evidence of coercion into assisted dying been forthcoming. Indeed, as shown by Julian Gardner and Alison Payne's evidence quoted above, we should be more concerned about coercion being used to *discourage* assisted dying.

Critics of assisted dying legislation also raise the possibility of "invisible" or "hidden" coercion,[9] in which individuals are pressured into pursuing an assisted death by dint of their specific vulnerabilities, for example their economic circumstances[10] or disabilities.[11] If this hypothesis were true, we would expect to see higher uptake of assisted dying amongst groups who are vulnerable in these respects. In fact, the opposite is true. Studies – drawing on data from Belgium, Canada, the Netherlands, and Oregon, covering a wide variety of different eligibility conditions – consistently

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[2] committees.parliament.uk/writtenevidence/115729/pdf// p. 1.
[3] https://www.parliament.scot/api/sitecore/CustomMedia/OfficialReport?meetingId=16078 p. 13. Italics added.
[4] committees.parliament.uk/oralevidence/12955/pdf/ pp. 28, 35.
[5] ibid. p. 31.
[6] ibid. p. 34.
[7] E.g. Care Not Killing (https://carenotkilling.org.uk/issues/pressure-and-coercion/).
[8] For example, coercion was the most-often cited concern for MSPs in the Stage 1 debate on 13 May 2025, where the Assisted Dying For Terminally Ill Adults (Scotland) Bill was considered: over two thirds of speakers in this debate mentioned concerns about coercion, including almost all MSPs who indicated that they were still weighing how to vote at Stage 3. See https://www.parliament.scot/chamber-and-committees/official-report/search-what-was-said-in-parliament/meeting-of-parliament-13-05-2025?meeting=16411&iob=140176.
[9] MSPs in the 13 May 2025 debate raised this point repeatedly. See, for example, speeches by Bob Doris MSP ('Coercion can be very subtle and difficult to detect'), Michael Matheson MSP ('detecting coercion and control would be a very serious challenge'), and Sue Webber MSP ('subtle pressure and coercion … are not always visible, and they do not need to be spoken out loud.' See https://www.parliament.scot/chamber-and-committees/official-report/search-what-was-said-in-parliament/meeting-of-parliament-13-05-2025?meeting=16411&iob=140176 p. 37 et passim.
[10] E.g. Christian Action, Research, and Education: https://care.org.uk/news/2024/10/poor-lonely-and-homeless-opting-for-assisted-death-in-canada.
[11] E.g. Disability Rights UK: https://www.disabilityrightsuk.org/news/dr-uks-statement-passing-assisted-dying-bill.

show that there is *less* uptake of assisted dying amongst vulnerable groups.[12] This is the opposite of what we would expect if vulnerability were a factor. As Dr James Downar, a Canadian palliative care physician and researcher put it in his evidence to the Health and Social Care Select Committee at Westminster:

> We do expect people requesting MAiD [Medical Assistance in Dying] from every demographic, as suffering is not limited to the privileged. But if vulnerability was driving MAiD requests, MAiD would be more common in structurally vulnerable groups; in reality, MAiD is substantially less common in these groups.[13]

Since the key hypothesis is that coercion is operating via these vulnerabilities, this data gives evidence to refute that hypothesis.

2. This lack of evidence is unsurprising, because medical professionals already possess knowledge and protocols to satisfactorily address risks of coercion at the end of life.

Medical professionals already have to deal with risks of coercion in many domains, even where assisted dying is not legal. Competent adults already have the right to refuse life-saving treatment, including through written advance directives.[14] They might be pressured by family members in their decision making—for example to end their lives early or, indeed, to request care they do not really want. Being vigilant for such coercion is part of standard medical practice for practitioners treating patients at the end of life. While assisted dying cases may be novel immediately following legalisation, the signals for a practitioner to attend to will be familiar. As Professor Ben White testified, when discussing the training provided to practitioners in Australia:

> A specific component is focused on training doctors in detecting coercion and in the sorts of conversations to have. We should recognise that medical doctors have such conversations with patients in relation to other end-of-life decisions. In end-of-life practice, doctors routinely assess capacity to ensure that decisions are ones that people want to make.[15]

It is a good general principle that our approach to the risk of coercion in assisted dying should be consistent with, and inspired by, the approach we take to that risk elsewhere. That means ensuring

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[12] E.g. Downar, J., Fowler, R. A., Halko, R., Huyer, L. D., Hill, A. D., & Gibson, J. L. (2020). Early experience with medical assistance in dying in Ontario, Canada: A cohort study. Canadian Medical Association Journal, 192, E173–E181; K. Hedberg, & C. New (2017). Oregon's Death With Dignity Act: 20 years of experience to inform the debate. *Annals of Internal Medicine*, 167, 579–583; F. Norwood, G. Kimsma, & M. P. Battin (2009). Vulnerability and the 'slippery slope' at the end-of-life: A qualitative study of euthanasia, general practice and home death in the Netherlands. *Family Practice*, 26, 472–480; Redelmeier, D., Ng, K., Thiruchelvam, D., & Shafir, E (2021). Association of socioeconomic status with medical assistance in dying: A case-control analysis. BMJ Open, 11, e043547; Smets, T., Bilsen, J., Cohen, J., Rurup, M. L., & Deliens, L. (2010). Legal euthanasia in Belgium: Characteristics of all reported euthanasia cases. *Medical Care, 48*, 187–192; M. C. Snijdewind, D. L. Willems, L. Deliens, B. D. Onwuteaka-Philipsen, & K. Chambaere (2015). A study of the first year of the end-of-life clinic for physician-assisted dying in the Netherlands. *JAMA Internal Medicine*, 175, 1633–1640; N. Steck, C. Junker, M. Maessen, T. Reisch, M. Zwahlen, M. Egger, for the Swiss National Cohort. (2014). Suicide assisted by right-to-die associations: A population based cohort study. *International Journal of Epidemiology*, 43, 614–622; van Wesemael, Y., Cohen, J., Bilsen, J., Smets, T., Onwuteaka-Philipsen, B., & Deliens, L. (2011). Process and outcomes of euthanasia requests under the Belgian Act on Euthanasia: A nationwide survey. *Journal of Pain and Symptom Management*, 721–733, 731.

[13] https://committees.parliament.uk/writtenevidence/115997/pdf/ pp. 1-2.

[14] https://www.nhs.uk/tests-and-treatments/end-of-life-care/planning-ahead/advance-decision-to-refuse-treatment/.

[15] https://www.parliament.scot/api/sitecore/CustomMedia/OfficialReport?meetingId=16078.

that patients are competent, checking that their choices represent what they really want, and providing them with the time, information and support they need. It means being vigilant for signs of undue pressure, and having procedures to follow if there are concerns. But there are no grounds for thinking that assisted dying presents novel challenges to medical professionals with respect to preventing coerced choices.

Crucially, though, our general approach to the risk of coercion in medicine is not to disempower people in the name of 'protection.' Coercion is wrongful because, amongst other things, it undermines the victim's autonomy.[16] Seeking to remedy it by restricting choice is misguided, because that too undermines autonomy. Rather, good medical practice counters the risk of coercion by empowering individuals to make decisions that align with their values. A consistent approach to the risk of coercion at end-of-life should do the same thing, by upholding the choice of an assisted death.

3. In evaluating the risks of assisted dying, the known risks of preventing lawful assisted dying must also be given due consideration.

In attending solely to the risk that someone might be coerced into choosing an assisted death, we fall prey to the well-established psychological bias of over-estimating novel risks while neglecting the continuous risks associated with the status quo.[17] Those risks include the risk mentioned above, of being coerced to accept unwanted treatment, and others too: unnecessary suffering, loss of dignity, and loss of autonomy. They currently affect everyone who would be eligible for assisted dying and would—given the option—make an autonomous choice to end their life.

Given this multi-dimensional predicament, it is important to take all risks into account. Policy in this area should seek to balance protections across the range of risks, rather than taking the risk of coercion out of context. As one of us has written in a previously published study:

> [treating this risk differently] would be inconsistent with what we do in all other risky areas of public policy, and would ignore the central point that the status quo is intolerable because it *necessitates* ongoing harms not lesser than the *possible* abuses of assisted dying laws.[18]

The legislation currently under consideration in the Scottish Parliament includes various protections against risks of misuse.[19] These include restrictions on who can avail themselves of assisted dying—only competent adults, resident in Scotland, with a diagnosed terminal illness. They also include procedural safeguards, such as requiring the sign-off of two independent doctors. While these features of the law risk stopping some people from receiving an assisted death who would, ideally, have the option to choose it, they aim to minimize risks overall. This is preferable to a policy without protections, but also preferable to one that completely prohibits the choice of an assisted death.

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[16] Colburn, B. (2024) *Moral Blackmail: Coercion, Responsibility, and Global Justice*. New York: Routledge: pp. 8-9.
[17] Slovic, P. (1987) 'Perception of risk', *Science* 236 (4799): 280-285.
[18] Colburn, B. (2022) Disability-based arguments against assisted dying laws. *Bioethics* 36: 680-686.
[19] https://www.parliament.scot/bills-and-laws/bills/s6/assisted-dying-for-terminally-ill-adults-scotland-bill.

4. The legalization of assisted dying opens the practice up to legal and regulatory scrutiny that reduces the risk of coercion.

The legal prohibition of assisted dying is advocated as a way to prevent coercion. However, we know that assisted dying takes place even when it is illegal. Medical practitioners already assist people to die, in a number of different ways.[20] People with terminal illness choose to end their lives by refusing treatment engaging in suicide, or – if they have the resources – travelling to permissive regimes like Switzerland.[21] With respect to these existing and widespread practices, the question arises: what is most likely to be effective at preventing coercion?

The answer is: legalisation with strong anti-coercion provisions, for the following three reasons.

First, it offers legal clarity to doctors and family members who might want to help suffering patients end their lives but risk prosecution for doing so.[22]

Second, as detailed above, it provides protections for patients. Procedural safeguards in the proposed Scottish bill include requiring the sign-off of two doctors acting independently who both confirm the patient's eligibility, having an additional unrelated witness to a patient's declaration of their choice of assisted death, a mandated period of reflection of fourteen days, and several others.[23] These are much more robust protections than exist for any of the currently legal ways that someone can hasten their own death—such as by refusing treatment.

Third, the proposed Scottish bill introduces specific criminal offences for anyone who uses dishonesty, coercion or pressure to induce someone into an assisted death.[24] This will provide legal clarity as to what is legally permitted *and* what is not.

Conclusions

People sometimes oppose assisted dying laws because of understandable and serious concerns about the risk of coercion. However, those concerns aren't borne out by the evidence. There is no evidence of coercion, including of vulnerable people. A consistent evidence-based approach to risk suggests that legalisation strikes a better balance of the risks to patients at the end of their lives. So, this policy paper has two key recommendations:

1. **Assisted dying laws should not be opposed on the basis of concerns about the risk of people being coerced into choosing an assisted death;**
2. **Appropriate assisted dying legislation can strengthen protections against coercion for people at the end of life.**

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[20] Seale, C. (2006) 'National survey of end-of-life decisions made by UK medical practitioners', *Palliative Medicine* 20: 3-10; Ward, A. (2022) *From Criminality to Compassion: Reforming Scots law on a Fullerian, compassion-based analysis,* PhD thesis, University of Strathclyde, pp. 180 et passim. https://stax.strath.ac.uk/concern/theses/z890rt783.
[21] Richards, N. (2017) 'Assisted Suicide as a Remedy for Suffering? End-of-Life Preferences of British "Suicide Tourists". *Medical Anthropology* 36: 348-362.
[22] Ward, A. (2022) *From Criminality to Compassion: Reforming Scots law on a Fullerian, compassion-based analysis,* PhD thesis, University of Strathclyde, pp. 291-329. https://stax.strath.ac.uk/concern/theses/z890rt783.
[23] https://www.parliament.scot/-/media/files/legislation/bills/s6-bills/assisted-dying-for-terminally-ill-adults-scotland-bill/introduction/bill-as-introduced.pdf §§4-10.
[24] ibid. §21.