

Opening statement – Dr Mary Neal (Reader in Law, University of Strathclyde)

Thank you for the opportunity to address the Joint Committee on the vitally important subject of protection for professionals. In my view, adequate protection for professionals is possible, and should be a priority for any legislature considering a change to the law in this area.

I will focus specifically on the challenge of accommodating conscientious objection: this arises where a professional who would otherwise be expected to have a role in the assisted dying process needs to opt out of participating because to do so would violate their moral and professional integrity. So, what do professionals need to be protected from, and what's the best way of achieving that?

In general, what they need to be protected from is sharing in moral responsibility for an outcome they believe to be seriously morally wrong. This is what a conscience clause is for. Precisely what *actions* professionals will need to be protected from having to do will depend on the way that a system of assisted dying is set up, and what role it envisages for professionals. All attempts to change the law in the UK have envisaged a role for health professionals, and we see health professionals having involvement in the assisted dying process in those jurisdictions that already allow it. Their roles might involve the giving of information; discussing treatment options and advising patients about those options; assessing patients' eligibility for assisted dying, and their capacity to make requests for assisted dying; prescribing and/or supplying medication for use in ending life; providing other forms of care to patients who are progressing through the stages of an assisted dying process; and completing paperwork during and after the process. (This is not an exhaustive list.)

Protection for conscience needs to be meaningful, and not partial. By this, I mean that a system in which professionals are given the right to opt out, but only from so-called 'direct' involvement, or only on condition that they refer the patient on to another provider, doesn't really fulfil the main purpose of a conscience clause; namely, to protect the professional from sharing in moral responsibility. As soon as we reflect on the nature of moral responsibility it becomes clear that those who facilitate or support outcomes, even in indirect ways, and even by signposting, share in the responsibility for those outcomes. Forcing morally-conflicted professionals to be 'indirectly' involved, or to refer patients to other providers, also risks creating nodes of anxiety, distress, and delay in the process that can also impact on patients. So 'partial protection' is in my view the least desirable way of accommodating conscientious objection, for professionals and patients alike.

The best way of protecting professionals, in my view, is to design the system so that, insofar as is possible, only those professionals who actively want to participate in the process need do so. Again, it's difficult to imagine how this might look without knowing what the whole system would look like, but it might involve an 'opt in system' across the country as a whole; or it might involve creating specific positions or roles for providers of assisted dying. Legislating about *where* assisted dying is permitted to take place might be another way of designing a lot of the potential for objection out of the system. For example, in the UK, most abortion is provided by specialist clinics, where all employees are obviously willing to participate in providing it. Some abortions still need to be provided in hospitals, where conscientious objection can arise, but as far as the great majority of provision is concerned, conscientious objection is avoided. Similarly, much assisted dying could take place in specialist clinics, where conscientious objection is not an issue. Of course, some patients who want to access assisted dying will be in hospitals or hospices, or in their own homes, and might be unable to travel to clinics; however, much of the scope for objections might be avoided if specialist clinics existed. Using one of these strategies, or a combination of them, would be far preferable to an 'opt out' system in which the onus is on those who object, because just as with abortion, it's much better for both patients and professionals for the issue of conscientious objection not to arise, and for the service to be provided smoothly by willing providers.

There is evidence that levels of conscientious objection to assisted dying are relatively high within the health professions (much higher in the UK than levels of objection to abortion, for example). Legalisation has a normalising effect, so once a new law was in place, you might see levels of objection softening. However, I think it would be a mistake to rely on that, and any attempt to change the law should plan for whatever the current levels are within the relevant professions; so I think a large-scale survey of the relevant professions should certainly be conducted to inform the present process, if that hasn't been done already.