SUPPLEMENTARY REPORT

OF THE

CHURCH AND SOCIETY COUNCIL
END OF LIFE ASSISTANCE (SCOTLAND) BILL

MAY 2010

PROPOSED DELIVERANCE

The General Assembly:

1. Receive the Supplementary Report.
2. Reaffirm the opposition of the Church to any legislation which allows assisted dying.
3. Instruct the Church and Society Council to continue campaigning against any such legislation.
4. Urge members of the Church to act to make clear their opposition to this legislation.

REPORT

1. Background

1.1 In December 2008, Margo MacDonald MSP (Independent) published her Consultation paper, The Proposed End of Life Choices (Scotland) Bill. This has now progressed to the introduction in the Scottish Parliament, on 20 January 2010, of a Bill, the End of Life Assistance (Scotland) Bill. Although it was expected that this Bill would be scruitinsed by the Health and Sport Committee, a six- member *ad hoc* Committee has been formed to scrutinise the proposed legislation. A call for written evidence to this committee was issued on 10 Feb 2010; the deadline for submission is 12 May 2010[1], after which point oral evidence will be taken. The Parliament has agreed that the deadline for the end of consideration of Stage 1 of the End of Life Assistance (Scotland) Bill is to be 24 November 2010. All MSPs have been given the freedom to vote on conscience, rather than the vote being subject to party whips.

2. The Church and assisted dying

2.1 The Church of Scotland has consistently opposed any legislation which would allow the deliberate ending of a human life, and has produced a number of reports in this area. For a fuller exploration of the position of the Church, interested readers are referred to the Church reports on Euthanasia of 1997[2] and 2008[3], and End of Life Issues in 2009[4].

[1] See http://www.scottish.parliament.uk/s3/committees/endLifeAsstBill/currentInquiries.htm

[2] http://www.churchofscotland.org.uk/councils/churchsociety/downloads/cseuthanasiabook.pdf

[3] http://www.churchofscotland.org.uk/councils/churchsociety/downloads/cseuthanasiasupplement08.pdf

[4] http://www.churchofscotland.org.uk/councils/churchsociety/downloads/csendoflifeissues09.pdf

2.2 The Church reaffirms its commitment to caring for the most vulnerable in society. Part of this work involves ensuring that as far as possible all have access to good palliative care - which, in the widest sense, involves caring not just for the physical but also the emotional and spiritual needs of people coming towards the end of their lives.

2.3 The Church fundamentally disagrees with the proposed legislation, which, despite what those who advocate legalising assisted dying argue, represents much more than simply a tinkering with the law. Such legislation would violate the sanctity of life. Breaching as it does the societal prohibition on the taking of human life, it carries implications for attitudes to many aspects of health and social care, not simply for the determined few who are pushing for change. Members of the Church are strongly urged to make representation to their MSPs in this regard. It is also proposed that a written response will be submitted to the questions posed by the End of Life Assistance (Scotland) Bill committee, and that the Church and Society Council, on behalf of the Church of Scotland, participate in a number of campaigns in conjunction with selected other organisations in opposing this legislation.

3. Critiques of the End of Life Assistance (Scotland) Bill

3.1 The following are developments of a number of specific arguments in relation to both the principles behind such legislation and the specific text of the Bill and supporting documentation as presented to the Scottish Parliament by Margo MacDonald, MSP. We are grateful to a number of people, particularly Dr Stephen Hutchison, Consultant Physician in Palliative Medicine, who have helped develop many of these points.

3.2 Dignity: Human dignity is a very complex but extremely important issue which cannot simply be reduced to the manner in which a person considers him or herself. It is also erroneous, and agenda-driven, to define dignity in care, and in dying, simply in terms of the availability of assisted dying. The term "dignity" is used loosely in the Bill, so that it is presented as an objective and clearly defined entity, embodied by assisted dying. The issue of dignity in care and dying has been extensively explored in the medical literature[5]. There is a necessity to accept that death is a natural process, and that not every death is a medical failure. What is a good death? What is a dignified death? Arguably assisted dying is *less* dignified than the natural process because of the requirement to submit to a formal protocol, with numerous perfunctory consultations, scrutiny of one's mental health, and with possible significant cost[6], within a short time frame and without the opportunity to discuss hesitation or distress lest that should be interpreted as a revocation, all at a time when life is already deemed to be intolerable.

3.3 Autonomy: Among the major arguments often advanced in favour of assisted dying is that of autonomy. However, it must be recognised that none of us is truly autonomous: we are all interconnected, and all actions or decisions have consequences for others around us. Clauses 2, 4 & 5 of the Bill state that end of life assistance may be provided under this Act only where two formal requests have been made to a registered medical practitioner, and *where that practitioner approves the requests*. Essentially therefore, although the Bill seeks to promote *individual autonomy*, it acknowledges that autonomy is at the very least a limited concept, and cannot be exercised in isolation in society. Likewise, the concept of a person being a burden to society is inimical to autonomy, as somebody who truly autonomous by definition cannot be a burden.

3.4 Euthanasia, physician assisted suicide (PAS) or assisted suicide?: It is unclear from the Bill exactly what

[5] See, for example: Chochinov, H.M.: *Dignity and the essence of medicine: the A, B, C, and D of dignity conserving care.* British Medical Journal 335: 184-187 (2007)

[6] See Explanatory Notes to Macdonald Bill, paragraph 108

form of assisted dying is being proposed. It is wholly inadequate to present the purposes of the Bill in anything less than unequivocally transparent language. Clause 1 of the Bill states that end of life assistance in this Act means *"provision or administration of appropriate means to enable a person to die"* The words '*provision or administration of appropriate means . . .*' suggest that this Bill seeks to legalise both assisted suicide and euthanasia. In addition, the Bill allows for assistance to be given by persons other than a physician.

3.5 Costs, coercion and the vulnerable: One of the major concerns that is raised in any discussion around assisted dying is the necessity to protect the vulnerable members of our society. While the Bill does attempt to address the matter of coercion of vulnerable people into seeking assisted death, the procedure outlined inevitably depends to a degree on the integrity of the doctor, witnesses, and of friends or family, and on how they should respond to the requesting person. For instance, if a requesting person tells the designated practitioner, psychiatrist(s) or witnesses, that the family are in agreement with the proposed ending of life, should that be interpreted as *coercion* or *undue influence*, or as straightforward concurrence? The comments in the documentation supporting the Bill[7] that the cost of assisted dying are likely to be substantially less than the cost of ongoing care are extremely alarming. No assurance can realistically be given that, under legislation of this type, straight-forward financial considerations would never influence a decision on whether or not to terminate a life. It would be impossible for a doctor tell whether or not someone was asking for 'assisted dying' simply out of a desire to spare the family a care or financial burden.

3.6 Medical practitioners: Legislation of this type places responsibilities on doctors and other health care professionals which would create a paradigm shift in their relationship with their patients, which is currently one based on care, and of preserving and protecting rather than ending of life. The professional bodies representing medical practitioners in the UK oppose any such legislation. The Bill as currently framed also provides no conscience clause for doctors. The Policy Memorandum incorrectly states that General Medical Council (GMC) guidance is that *"there would be a duty on registered medical practitioners who object to participating to make arrangements to see a registered medical practitioner who would be prepared to consider a request for end of life assistance"*. The GMC guidance quoted is given in the context of the principle of protecting and preserving life and it is questionable to assume that the same guidance would apply to the deliberate ending of life. In fact there is no mention of end of life assistance in this GMC document and it therefore cannot be inferred that the GMC, whose current position is that "An act where the doctor's primary intention is to bring about the patient's death would be unlawful", would oblige doctors to participate in the assisted dying process.

3.7 Anxiety and distress: Clause 3 states that the requesting person may give notice that they no longer wish to go through with the procedure- an apparent safeguard for articulate individuals, but the *'however informal'* description is impossible to interpret with certainty. Does that include expression of reservations or anxieties about the procedure? Many people at some stage time during such a process would say something like *"I hope I'm doing the right thing"*. Does that constitute an informal revocation of the request? This potentially *inhibits* the expression and discussion of anxieties and distress around the end of life lest this should be interpreted as a revocation. In the context of a life or death decision, it is impossible for the doctor to determine with certainty what would and what would not amount to an informal revocation.

3.8 Scientific evidence: "evidence" is often misappropriated, and emotive language employed in a

[7] See paragraphs 97 and 110 of the Explanatory Notes accompanying the Bill.

manner wholly inappropriate for legislation. For example, paragraph 51 of the Policy Memorandum quotes a Belgian study published in the British Medical Journal (BMJ) to support the contention that palliative care and assisted death complement one another. The Memorandum makes no mention of the criticism this paper received in a BMJ editorial[8], which states: *"The data actually show that ….it would be a mistake to suggest that these findings dispel concerns about euthanasia or that they support including euthanasia within palliative care."* No reference is made to a firm recommendation in the medical literature, on the basis of experience, that assisted suicide and euthanasia should *not* be practiced in palliative care units[9].

4. Conclusion

4.1 It cannot be too strongly emphasised that this Bill proposes fundamental changes to the whole basis on which we provide care for patients in our country, and thus has implications for all of society as to how we view precious human life. Experience elsewhere reflects progressive weakening of any "safeguards" against abuse which might be put in place, and concerns about this are legitimate. Quotes from Lord Carlile and Baroness Cumberlege suggest that it is naïve to think that safe legislation can be drawn up on this m atter or that the procedures are necessarily straightforward.

> **"Laws aren't like precision-guided missiles. You can't draft them in the comfort of a Westminster chamber and then just 'fire and forget'. Once they are on the statute book they have a habit of causing collateral damage well beyond the intended target area."**[10]
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> Lord Carlile of Berriew,
> Member of the House of Lords Select Committee
> on the Assisted Dying for the Terminally Ill Bill

> **"The medical profession is there to treat, cure, and care for sick and disabled people. Once lawyers get involved the whole premise changes: bitterness, strife, and serious money take over, families are divided, and suspicion reigns. Doctors should steer clear of assisted suicide – or more accurately of putting people to death – if they want to retain the trust of their patients."**[11]
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> Julia Cumberlege,
> former health minister, House of Lords

4.2 The Church and Society Council would strongly urge that the proposed End of Life Assistance (Scotland) Bill be rejected.

In the name and by the authority of the council

IAN F GALLOWAY, *Convener*
ALEXANDER G HORSBURGH, *Vice-Convener*
EWAN R AITKEN, *Council Secretary*

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[8] BMJ 2009;339:b2730

[9] Pereira *et al*, J. Pall Med 11: 1074-6 (2008)

[10] See, for example: All Party Parliamentary Group on Dying Well. http://www.dyingwell.org.uk/index.php?option=com_content&view=article&id=30:the-slippery-slope-is-no-fiction-says-lord-carlile&catid=4:publications&Itemid=2

[11] BMJ 2009;339:b3422