

Assisted Suicide (Scotland) Bill

Church of Scotland Church and Society Council

1. Do you agree with the general purpose of the Bill to make it permissible, in the circumstances provided for, to assist another to commit suicide?

The Church of Scotland reaffirms that an important aspect of our ministry is providing pastoral support to both individuals and communities, and particularly in caring for the most vulnerable in society. Our ministers and others spend much time alongside people who are close to death and feel their pain. We are therefore sympathetic towards the fears and desires of those who may be afraid of a death which is painful, or where people fear the sense of dependency or powerlessness which may characterise various degenerative diseases.

However, we are clear that what is proposed in this Bill is not the best solution. Rather, there is a necessity to ensure that, as far as possible, all have access to good palliative care. This, 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. There is also a need to accept the inevitability of death, and that there are times when medical interventions are inappropriate.

The Church fundamentally disagrees with the proposed legislation, which represents much more than simply a tinkering with the law. Such legislation, breaching as it does the societal prohibition on the taking of human life, carries implications for the whole of society, and for attitudes to many aspects of health and social care. It has profoundly negative implications for the most vulnerable in society, who may already feel voiceless and marginalised. These implications and concerns of those who will be most directly affected must carry as much importance as the views expressed by those who are pushing for a change in the law.

The modern world has seen changes to family life with increasing numbers of people living geographically apart from their relations. The ways in which care and support for the vulnerable are provided therefore also need to change. While this Bill may represent an attempt to address some of these issues, as a society we need to do better.

2. Do you have any views on how the provisions in this Bill compare with those from the previous End of Life Assistance (Scotland) Bill?

We are concerned that, in many ways, the proposed legislation is even more open to abuse than was the previous Bill, which was decisively rejected by the Scottish Parliament in 2010. For example, use of very broad terminology such as “life shortening” as a qualifying condition. People with diabetes or epilepsy die younger than average (see <http://www.nhs.uk/news/2013/07July/Pages/People-with-epilepsy-have->

higher-risk-of-early-death.aspx), so epilepsy sufferers could therefore be defined as people qualifying for assisted suicide under this Bill. Diabetes is also life shortening and affects a much larger proportion of the population; does the proposed legislation wish to allow all diabetics the option of killing themselves if they develop one of the complications, such as vascular disease (possible amputation), eye problems (possible blindness), or renal failure (possible dialysis +/- transplantation)?

Also, following criticisms of the provision for assessments of the mental health of those seeking assisted suicide in the previous version of the Bill, rather than make any attempt to tighten or improve that aspect of the Bill, the response of the proposers has simply been to remove any requirement for an assessment of mental health at all!

3. The Bill precludes any criminal and civil liability for those providing assistance, providing the processes and requirements set out in the Bill have been adhered to. Do you wish to make any comment on this?

In many ways, this prevention of prosecution of those carrying out the assistance seems to be the main purpose of the legislation. The law as it stands, which makes it an offence for anybody to assist another person to attempt or complete suicide, is straight forward. To allow for provision of assistance in **some** circumstances would mean that there is **always** the possibility of abuse of any "safeguards" included. Motivations of all involved would need to be assessed, which may be difficult. For example, families under pressure may make subtle (perhaps even unintentional or misunderstood) suggestions to their relatives that the best and most honourable thing to do would be to seek assistance to die. Such suggestions may be difficult for those outside the family to detect.

Or if, for example, a resident of a care home were to seek assistance to end their own life, how this would affect other less able residents of the care home? This is not simply about the attitudes of staff or family members; it is about how a person experiences the expectations of those around them. It is not possible to provide a legal process which can check whether a vulnerable person, dependent on the care of others, is acting freely.

4. The Bill outlines a three stage declaration and request process that would be required to be followed by an individual seeking assisted suicide. Do you have any comment on the process being proposed?

Any process of this type almost inevitably runs the risk of becoming, in the hard-pressed context of caring for those near death, a "tick box" exercise, where procedures are superficially adhered to, but the main reason behind the protocol is lost. Witness, for example, the recent situation with regard to the Liverpool Care Pathway in end of life care. The pathway becomes a one-way street.

We need to explore in more detail how society understands, communicates and discusses death, dying and bereavement. One of the issues which a debate such as this reveals is the sense of loss of control which patients and their families sometimes feel as death approaches. We must beware of medical models which can depersonalise, and also need to avoid inappropriately aggressive medical interventions as people near the end of their lives: the (sometimes implicit) view that every death is a medical failure needs to be challenged. Care is spiritual as well as physical. There is a great fear of a painful death, which can be mitigated, although not always completely removed, by palliative care.

5. Do you have any comment on the provisions requiring that the person seeking assisted suicide must have a terminal or life-shortening illness, or a progressive condition which is either terminal or life-shortening?

As has already been pointed out, the terminology used in the Bill is so broad as to be almost pointless, and provides essentially no protection against abuse. The Member who introduced the Bill has made it clear that the ultimate intention, if any such legislation were introduced, would be that the categories of those eligible to be assisted to die be extended (see Assisted Suicide (Scotland) Bill Policy Memorandum http://www.scottish.parliament.uk/S4_Bills/Assisted%20Suicide/b40s4-introd-pm.pdf sect 54).

In addition, we would wish to express concern about illnesses such as dementia in which there may be minimal medical treatment or intervention but a high need for care, which may be expensive. While it would never be put in such stark terms by its advocates, assisted dying saves money for health boards or for relatives, it could come to be seen as the cheapest option. We need to ensure protection of the weak and vulnerable, of people who cannot argue against being led down a particular route—remembering that not every family is a supportive and caring family, seeking the best for their relative.

6. Are you satisfied with the eligibility requirements as regards age, capacity, and connection with Scotland as set out in the Bill?

As we have already said, we feel that no amount of “safeguards” will ever be able to completely prevent abuse.

7. Do you have any comment on the roles of medical practitioners and pharmacists as provided for in the Bill?

One of the most disturbing aspects of this proposed legislation is that it requires members of the medical and allied professions such as pharmacy to be active participants in the process of assisted suicide. As has already been pointed out, death is a natural process. It is clear that there is a role for the medical profession in supporting people at the end of their lives; however, that role should not include the intentional ending of life.

The great majority of health care professionals and their representative bodies have consistently opposed legalising assisted suicide. Requiring members of the medical profession to be involved in intentionally ending life would fundamentally change the relationship between medical professionals and the society they serve. This is a point of principle which goes beyond the individual practitioner and the individual patient. While a conscience clause would enable individuals to opt out of participation in this process, there would also be practical problems- for example, in rural areas where alternative practitioners may not be available. It would also be a problem in urban areas where, if the patient's own doctor refused to participate, the patient would have to hawk themselves around to try to find a doctor prepared to do it.

8. Do you have any comment on the means by which a person would be permitted to end his/her life under the Bill?

While we appreciate the proposers' motivation in not stipulating the means of death, we would be concerned that, in the current draft of the Bill, no limits at all are placed on how the person is assisted in ending their lives.

9. Do you have any comment on the role of licensed facilitators as provided for in the Bill?

We have concerns about many aspects relating to the proposed facilitator. For example, facilitators are there to give "such practical assistance as the person reasonably needs". What are the limits of the assistance that the facilitator is able to give in, for example, lifting the cup to the lips of the person seeking to complete suicide?

The description of the way in which licensed facilitators would act seems to suggest that the suicide (or attempted suicide) would take place at the person's home. While we can understand why the proposers of the Bill would wish to do this, there are clear risks inherent in the final death not happening near medical professionals. For example if there was a mistake made in the administration of the drugs, the person could be left in great pain while paramedics come to their aid; if it were done in a more controlled medical environment the person could receive aid more quickly in the event of maladministration. Also, we are concerned about the fact that drug with the ability and intention to cause death could be available outside a controlled medical environment, and could be used accidentally by someone else, misplaced, or stolen, more easily than if they were secured in a medical facility.

10. Do you have any comment on the role of the police as provided for in the Bill?

11. Do you have any comment to make about the Bill not already covered in your answers to the questions above?

There is a need to accept that death is a natural process, and that not

every death is a medical failure. What is a good or a dignified death? Arguably assisted dying, as envisaged by this Bill, is less dignified than the natural process because of the requirement to submit to a formal protocol, with numerous consultations, etc.

Much of our opposition is motivated by a concern for the weakest and most vulnerable in our society. While the articulate and those with supportive families can get their voices heard, what of the marginalised? Prejudice against disabled people is already widespread and their quality of life underrated. Will this proposed legislation encourage doctors and nurses to fully explore the concerns of the disabled, and fight for their full lives, or will it undermine this work? Will those in our communities with disabilities get suicide prevention or suicide assistance?

While recognising that medicine is constantly improving our ability to deal with physical pain, we need to also be aware that the anguish around death is much more than a fear of pain. Palliative care, which takes care of all aspects of the person, needs to be made more widely available.

The current law, through its acceptance that some may wish to take their own lives, but its blanket prohibition of assisting another person to attempt or complete suicide, is clear, and provides a strong disincentive to abuse and exploitation whilst allowing prosecutors and judges discretion in hard cases. It does not, in our opinion, need changing.

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