

## **Assisted Suicide (Scotland) Bill**

### **The Faith and Order Board of General Synod of the Scottish Episcopal Church**

**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?**

No, and not at the present time. We would like questions about Assisted Suicide to be asked within a wider context. Any one person, let alone any one denomination, is likely to feel conflicted on this matter. Members of the Scottish Episcopal Church have a variety of views. See response to question 11 for considerations and elaboration.

**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 view favourably:

- the omission of voluntary euthanasia
- the seemingly narrower eligibility criteria (that a person's disability and inability to live independently are not sufficient to qualify for assisted suicide).

We are concerned that the Bill:

- does not require the presence or assistance of medical staff at the suicide
- does not stipulate the need for assessment by a psychiatrist.

**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?**

See responses to questions 1 and 11.

**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?**

We see a role of the Law as being to protect the vulnerable, and are concerned that some people may feel under pressure to make requests. It is not clear how this process would be policed.

**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?**

Our lives are lived in a progressive condition that is terminal and so these definitions do not offer clear delineation.

We would advocate palliative care being extended beyond cancer and heart care, and made available to all people who would like to receive it.

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

We share with others fears that provision for Assisted Dying will be extended

to children, as has been the case in Belgium. It will indeed be hard to make a case for allowing Assisted Suicide to a 16 year old whilst denying it to someone who is 15 years and 11 months old, and we may be taken towards legitimising assisted suicide for minors.

We acknowledge that Scotland has the advantage of seeing the law in operation in other places, and the freedom to decide how to manage its own legislation and practice on this matter. It is possible, for example, to set a limit of 16 years of age, which may seem arbitrary in that there is no discernible difference between 16 years and 15 years and 11 months, and to stick to this limit for regulatory reasons so as to provide the certainty that the law requires, as, for example, the limit of 14 days from fertilization for keeping a live embryo in the laboratory. These limits are not entirely arbitrary; there are reasons behind them, and any change would, we would ask, be made with extremely careful deliberation.

We hear the fear of many disability groups, that the Bill sends out a message that if you have certain conditions then life is not worth living, or that you lack dignity. As mentioned re question 4, we also fear that vulnerable people, including elderly people, may in time come to feel it as a duty not to go on living so as not to be a burden.

We are aware of the expressive function of the law; that when a law is changed, it also changes perceptions (for example, when wearing seatbelts became compulsory in law, this affected people's judgements about the non-wearing of seatbelts). The law is not neutral; it approves and disapproves of things. We are concerned that Assisted Suicide legislation would delineate an abject realm in which choosing to be assisted to die is perceived to be the reasonable thing to choose, such that not choosing it would somehow be unreasonable.

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

We are aware the professional bodies representing medical practitioners and pharmacists are opposed to the Bill, and would want assurance that no-one would be put under duress should the Bill become law.

We are concerned that where assisted dying is made legal, funding for palliative care may be reduced. The optimum outcome, were assisted suicide to become legal, would be it for it to be in conjunction with good palliative care, and for palliative care to be available to all who would benefit from 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?**

No.

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

It is not clear whether the facilitator would need to be present at the actual death, nor is it clear how facilitators would be selected, trained and funded.

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

The Bill would be hard to police. It would be hard to make a judgement that a person requesting Assisted Suicide was 'not persuaded or similarly influenced'.

There would need to be a reporting mechanism such that the police could ascertain who was involved in any particular death. This will be difficult if the licensed facilitator is not required to be present at a death.

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

i) We uphold the sanctity of human life, and this, alongside compassion, are our primary considerations when thinking about Assisted Suicide.

(1) We acknowledge that in Christian contexts the sanctity of human life is rarely an absolute, but rather is adhered to in contexts where the preservation of life might come second to some other good, such as justice (for example, where there have been arguments for just war), or self-sacrifice.

(2) Christian arguments in favour of Assisted Suicide, are usually offered on the grounds that compassion is in some circumstances a higher good than the preservation of life, and we have sympathy with that, and want to explore the transformative effects of compassion that broaden our responses to suffering (see iii) below).

(3) Christian arguments tend not to promote autonomy/the right to choose as a higher good than the preservation of life, although Swiss Roman Catholic theologian Hans Küng has argued that the all-merciful God, who has given men and women freedom and responsibility for their lives, has also left dying people the responsibility for making a conscientious decision about the manner and time of their deaths.

ii) We would like questions about Assisted Suicide to be asked within a wider context.

(1) We would like to see and contribute to a wider conversation in society about how to live our dying well; a conversation that will broaden this question out beyond purely medical considerations.

(2) People find it difficult to talk about death, and large numbers of people in Scotland have not made wills. The current trend of death cafés is helping us to overcome our taboos, but conversation in death cafés is primarily focussed on medical choices at the end of life. We are helped to face our mortality when we see death on a trajectory with other things that we face through life: change, saying goodbye, letting go, loss, limitations. By experiencing all of these things, we are getting some practice in for how to live our dying well. We can also hear and gain perspectives on the preciousness of life and the intensity of living close to death from those who are knowingly approaching their life's end. Learning these things is part of 'the art of dying'.

- (3) Discussion of assisted suicide is likely to look different in a context where the art of dying is remembered and practised as something that we can learn throughout our lives. Baroness Neuberger, in the Malcolm Goldsmith Lecture (Edinburgh, 11 March 2014), said that the art of dying began in eighteenth century when laudanum came to be used to combat pain. In other words, she saw the art of dying as a medical art to do with pain relief. But the art of dying is a spiritual art, learned emotionally and communally, and found in all religions and traditions. In Christian Europe, it grew with the plague and culminated in the Seventeenth Century in the work and words of Jeremy Taylor: 'Dying is an art, best learned by us in health'.
- iii) We want to explore compassion beyond the giving of drugs and legality of choosing death, and to look towards transformative possibilities.
- (1) Matters that people most dread about the end of their lives are loss of autonomy and loss of dignity. Intolerable pain is the third highest factor that people worry about ahead of time. About 90% of pain can be controlled by drugs but that leaves 10% that cannot, and we are realistic about that.
- (2) Loss of autonomy and loss of dignity cannot be palliated by drugs, and need a different response; one that is social, emotional and, for many people, spiritual. Loss of autonomy and loss of dignity cannot be 'fixed' but they can be transformed, and we need to look for what enables transformation, and to allow that transformation can take unforeseen positive directions. Loss of hope might seem like the worse loss of all, but when we lose hope we gain acceptance. New forms of hope may follow.
- (3) A related matter is the possibility of transforming the notion that people are a burden when they are ill and dying. Caring for others is deeply humanising and often felt to be a blessing. Just as some people say that the last few months of life have been the most intensely lived, and in some ways 'happy', so some people can say that caring for their dependent loved ones, with dementia or debilitating illnesses, have been the most precious times, or the culmination of their lives. These experiences need to be kept before us as possibilities, and as part of the conversation when facing very real fears about loss of autonomy and dignity.