The Church of Scotland

Official Response

Subject:	Proposed Assisted Dying for Terminally Ill Adults (Scotland) Bill
Requested by:	Liam McArthur MSP
Date:	22 December 2021
Prepared on behalf of:	The Faith Impact Forum

Q 1. Which of the following best expresses your view of the proposed Bill?

Our response: Fully opposed

The proposed Assisted Dying for Terminally Ill Adults (Scotland) Bill, if it was to become a new law, would allow terminally ill adults in Scotland to ask for assistance in ending their own lives.

Although the term "assisted dying" is used in the title of the proposed Bill, what is actually being proposed is assisted **suicide**: a change in the law to make it legal, in certain situations, to provide assistance to actively end the life of another person.

A recent public survey for the Westminster All Party Parliamentary Group for Dying Well indicates that there is confusion about the what the term "assisted dying" means. Only 43% of those interviewed correctly identified that the legal term "assisted dying" meant providing people with lethal drugs to end their life, with many respondents thinking instead that it means hospice, palliative and other forms of supportive care at the end of life, or giving terminally ill people the option of ending life-prolonging treatment. This proposed "Assisted Dying" Bill is about the right to have assistance to complete suicide.

The Church supports the existing law and protections around the end of life, and is opposed to a change to allow legally assisted suicide, or any other form of assisted dying.

Our experience in congregations and communities is about coming alongside people who are vulnerable and those seeking refuge, to provide support for those experiencing trauma and to walk with people through the valley of the shadow of death. The Church has extensive experience in caring, particularly for those at the end of their lives. The Church of Scotland seeks to show the love of Christ in supporting all--including those in our society who are most vulnerable.

While reaffirming the importance of caring for those approaching the end of their lives and supporting the extension of the provision of palliative care, the General Assembly of the Church of Scotland has consistently and repeatedly expressed its opposition to any change in the current law which precludes assisted dying in all its forms (including assisted suicide, physician-assisted suicide and euthanasia). This opposition is based on our Christian faith and involves concerns around the principle of assisted dying, around the application of the law in practice, and also the effect which any change is likely to have on the provision of care - in particular palliative care.

Principle: The current societal prohibition on killing is clear; to move away from this would involve more than a simple modification of the law, but would represent a significant shift from which there would be no return. This would have profound effects on how society regards those in our

communities who are vulnerable. This is not just the elderly and infirm, but also those with disabilities, and those who are unable to speak up to protect themselves.

Practice: In other jurisdictions where assisted dying has been allowed, the experience of framing and maintaining safeguards has been fraught with difficulties and frequently subject to removal or relaxation of restrictions to eligibility. In Canada, the law from 2016 has been amended in 2021 to remove the requirement for terminal illness, and there is currently debate to extend eligibility even further. Similar patterns have also been noted in the Netherlands: the law, passed in 2002, "has contributed to a normalization of physician-assisted dying and has led, due to its unavoidably flexible and ambiguous nature, to an expansion of its practice."

The acceptance by a society of legally assisted dying profoundly changes relationships not only between health professionals and patients, but also within families. As First Minister Nicola Sturgeon has put it: "I am … concerned about the difficulty that will, I think, always and inevitably be present in determining that someone who has chosen to end their life has not been subjected to undue influence."

Palliative care: We would advocate for the provision of more and better palliative care. Evidence is emerging from other jurisdictions that allowing assisted dying has had a negative effect on the provision of palliative care. In Canada, for example, participants in a research study "reported that Medical Assistance in Dying had consumed limited resources that would otherwise be used to provide palliative care". The end of a person's life involves not simply the point of death, but also the way in which they experience their final days and weeks. Were assisted dying to be introduced into the equation, the relationship between those cared for and those who have the duty to care (including family, health and social care professionals, but also society in general) is irredeemably altered. Life is lived and death experienced as part of community and society.

Q 2. Do you think legislation is required, or are there are other ways in which the Bill's aims could be achieved more effectively? Please explain the reasons for your response.

Our response: This legislation is NOT required.

In the vast majority of cases, properly delivered palliative care can effectively address the physical suffering of a terminally ill person. What is required is an improvement in the provision of end-of-life care, delivered by healthcare professionals with the relevant expertise.

Physical pain is not the major issue here. Loss of autonomy (87%), impaired quality of life (86%), and loss of dignity (69%) were the most common reasons for pursuing assisted dying in Oregon and Washington.

Palliative care not only includes medical assistance but endeavors to provide non-clinical support and the right environment for patients and their families to work through their distress. We would assert that it is important that the physical, emotional and spiritual needs of people approaching the end of their lives must be adequately addressed.

Q 3. Which of the following best expresses your view of the proposed process for assisted dying as set out at section 3.1 (Step 1 - Declaration, Step 2 - Reflection period, Step 3 - Prescribing/delivering)?

Our response: Fully opposed

As detailed above, we are opposed to assisted dying in principle. We also note with concern the negative effect which the introduction of assisted dying legislation has had on the provision of palliative care in other countries and states. Research has found that Medical Assistance in Dying has impacted palliative care providers personally and created new barriers to their relationship with patients; participants described how Medical Assistance in Dying has contributed to further stigmatization of palliative care and increased distress of individual palliative care providers around assisted death.

The introduction of assisted dying would profoundly change the relationship between those who require care and those who care for them - whether in a professional or a personal capacity.

Q 4. Which of the following best expresses your views of the safeguards proposed in section 1.1 of the consultation document?

Our response: Fully opposed

It is essentially impossible to effectively implement any safeguards which will ensure that no abuse of assisted suicide legislation takes place. In places where assisted dying has been legalised, analysis shows that this leads to an erosion of the protection of the most vulnerable in society. For example, a significant number of deaths by assisted dying in Belgium in 2013 were reported to be without consent - the elderly, the confused and those in a coma.

The supposed safeguard is based on the idea that eligibility is restricted. However, evidence from other jurisdictions indicates that, once legislation is passed, eligibility criteria are quickly loosened, and effective policing of these eligibility criteria is either lax or so impracticable as to be nigh on impossible. As Belgian legal scholar Etienne Montero has said: "The Belgian experience teaches that … it is very difficult to maintain a strict interpretation of the fixed legal conditions."

In addition, in countries such as Belgium and The Netherlands where legislation has been in place for a number of years, there is now evidence of a gradual widening of the categories of persons considered for assisted suicide with respect, for example, to age and the seriousness of the condition they are living with. As noted previously, Canada, Oregon, Belgium and the Netherlands have all expanded their criteria for assisted dying.

This is of particular concern here: as currently framed, "suffering," although mentioned often, does not seem to be a prerequisite for the provision of assisted dying in the proposed legislation. This clearly leaves space for the sort of widening of categories of eligibility which has been seen in other countries, which greatly concerns us.

Q5. Which of the following best expresses your view of a body being responsible for reporting and collecting data?

Our response: Fully opposed

There is good evidence, from Belgium and elsewhere, that such attempts to police the practice of assisted dying is ineffective. Research indicates that death certificates substantially underestimate the frequency of euthanasia as a cause of death in Belgium and are therefore an unreliable tool for monitoring its practice. Among doctors who affirmed that they had not reported a case of euthanasia, 18% stated that they did not do so because reporting was "too much of an administrative burden".

Despite this evidence, since euthanasia was legalised in 2002, the Belgian Commission charged with overseeing the practice has only referred one case to the Public Prosecutor - and the doctors involved were acquitted.

As Raus *et al*. pointed out, "Due to the anonymity and the concise nature of the reporting form, the Commission is unable to check whether particular legal criteria are in fact met, even though that is its main task. Furthermore, due to the Commission's composition and the authority it has taken upon itself, it might actually function as a shield, rather than a monitoring body."

There is thus a serious lack of accountability in Belgium relating to euthanasia and assisted dying procedures, which results in a lack of protection of the most vulnerable. The lack of accountability in other countries concerns us, as there is nothing to indicate the same will not happen in Scotland.

Q6. Please provide comment on how a conscientious objection (or other avenue to ensure voluntary participation by healthcare professionals) might best be facilitated.

Our response: n/a

As indicated previously, we are concerned that legislation allowing assisted dying will fundamentally alter the relationship of trust between those who provide healthcare and those who are being cared for. While provision must be made for healthcare professionals to withdraw from involvement in the act of assisted suicide against their wishes or personal beliefs, our concerns go much deeper.

Q7. Taking into account all those likely to be affected (including public sector bodies, businesses and individuals etc.), is the proposed Bill likely to lead to:

Our response: Don't know

We are very concerned with the implications regarding assisted dying being seen as providing a cost saving for health care. This is based on analysis from Canada (see footnote on page 28 of the consultation document), which states that:

"A cost analysis of assisted dying in Canada was undertaken in 2017 and concluded that 'Medical assistance in dying could reduce annual health care spending across Canada by between $34.7 million and $138.8 million, exceeding the $1.5–$14.8 million in direct costs associated with its implementation.' In sensitivity analyses, it was noted that even if the potential savings are overestimated and costs underestimated, the implementation of medical assistance in dying will likely remain at least cost neutral."

We are very concerned that the consultation indicates that the consideration of healthcare costs may be a factor in the legalization of assisted dying.

Q 8. What overall impact is the proposed Bill likely to have on equality, taking account of the following protected characteristics (under the Equality Act 2010): age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation?

Our response: Negative

As indicated previously, we are concerned that the introduction of assisted dying would have a disproportionate negative effect on the most vulnerable in our society - including the old, the voiceless, and those with disabilities. It has been argued that restrictions around previous assisted dying bills were discriminatory. Were it implemented, it is likely there would be immediate claims that the proposed McArthur Bill is discriminatory in that it only permits assisted dying for those who

are terminally ill and for those who have sufficient hand function and swallow to self-administer the medication. For example, a person with motor neurone disease may not be in the last 6 months of life nor be able to self-administer lethal medication. Therefore it is likely that, on grounds of equality, the legislation would be challenged in the courts and found wanting. There would then have to be introduction of doctor-administered medication and also removal of the terminally ill requirement, which would put the entire disability community at risk.

Q 9. In terms of assessing the proposed Bill's potential impact on sustainable development, you may wish to consider how it relates to the following principles:

Our response: Unsure

Q 10. Do you have any other additional comments or suggestions on the proposed Bill (which have not already been covered in any of your responses to earlier questions)?

Our responses:

Name of the Bill: As noted above, there is evidence to suggest there is confusion among the public about what "assisted dying" means. This "Assisted Dying" Bill is about the right to have assistance to attempt/complete suicide. Suicide is a term which is widely understood: the Bill should be renamed to allow a better and more informed public debate about important and sensitive issues.

Palliative care: A further concern is around the effect that the acceptance of assisted dying has on the provision of palliative care. There is evidence that, in those jurisdictions where assisted dying is allowed, there has been an impact on palliative care providers personally and on their relationships with patients; the consumption of palliative care resources to support assisted death was also noted. As Prof Claud Regnard, Honorary Consultant in Palliative Care Medicine in Newcastle-upon-Tyne has pointed out, in Canada, hospice funding has been withdrawn because they refused to participate in assisted deaths.

While the intention may have been to extend choice, in practice, due to finite resources, an inevitable tension between providing assisted suicide and those caring for the dying will develop.

In addition, official reports reveal that many whose death is assisted are not in the last phase of their illness but may choose that course for fear of being a burden. In Canada in 2019, 34% of those who were euthanised cited "perceived burden on family, friends or caregivers" as one of their main reasons for requesting assistance in dying.

Suicide: Scotland is already staggering under the burden of a higher rate of suicide than any other part of the UK. While many work to support those who are at risk due to self-harm or suicide, we feel that to allow a legally assisted form of suicide would send the wrong signal to this who are most vulnerable.

In conclusion: Were assisted dying to be introduced in Scotland, the relationship between those cared for and those who have the duty to care (including family, health and social care professionals, but also society in general) would be irredeemably altered. The end of a person's life involves not simply the moment of their death, but also the way in which they experience their final days and weeks.

While many who advocate assisted dying would point to the principle of autonomy and argue that one should have freedom to choose the timing and manner of one's own death, it must be remembered that all of our decisions and actions have effects on others. Life is lived and death experienced as part of community and society.

The Church of Scotland seeks to show the love of Christ in supporting all - including those in our society who are most the vulnerable. While respecting the sincerity of those promoting change, we remain opposed to any proposals to amend the law around assisted suicide.

1. A similar poll was conducted in New Zealand with similar findings. Of people who strongly supported assisted dying, >80% thought this included turning off life support.
2. The Canadian health services website states: "You do not need to have a fatal or terminal condition to be eligible for medical assistance in dying."
3. Select committee on the evolution of the Act respecting end-of-life care. Assemblée Nationale du Quebec.
4. Koopman J and Boer, T, Turning Points in the Conception and Regulation of Physician-Assisted Dying in the Netherlands. Am J Med. 129: 773-5. (2016)
5. Mathews JJ, *et al:* "Impact of Medical Assistance in Dying on palliative care: A qualitative study." Palliat Med. 35: 447-454 (2021)
6. Al Rabadi *et al*: Trends in Medical Aid in Dying in Oregon and Washington. JAMA Network Open. 2019. doi:10.1001/jamanetworkopen.2019.8648
7. Cohen-Almagor R. J Med Ethics 41: 625–629. doi:10.1136/medethics-2014-102387
8. Cohen J, *et al*: How accurately is euthanasia reported on death certificates in a country with legal euthanasia: a population-based study. Eur J Epidemiol. 33: 689-693 (2018)
9. Smets, *et al*: Reporting of euthanasia in medical practice in Flanders.
10. Belgium: cross sectional analysis of reported and unreported cases BMJ 2010;341:c5174
11. Raus *et al*: Euthanasia in Belgium: Shortcomings of the Law and Its Application and of the Monitoring of Practice. J Med Philos. 46: 80-107 (2021).
12. Sleeman K, Chalmers I. Assisted dying: restricting access to people with fewer than six months to live is discriminatory BMJ 2019; 367 :l6093 doi:10.1136/bmj.l6093
13. Mathews *et al*. Impact of Medical Assistance in Dying on palliative care: A qualitative study. Palliat Med. 35: 447-454 (2021)