

EUTHANASIA

Introduction:

The issue of euthanasia is one that reappears regularly in our public consciousness. For many, it is a close and personal concern – a real and often painful issue of life and death – and it is right that the Church should be at the heart of the debate. For many years, and on the basis of careful reports and compassionate consideration, the General Assembly of the Church of Scotland has held a clear line against any proposed legalisation that would permit euthanasia or assisted dying. The last major report appeared in 1994, with a revised version of this publication issued in 1997. This new supplement looks at how things have moved on in the debate since then, and our thanks are due to Dr John Berkeley for his time and care in its preparation. There have been significant medical advances, particularly in palliative and hospice care, and these are reflected here. However, the position of the Church of Scotland remains the same. We strive to reflect Christ's love for the vulnerable, the ill and the dying and in our words as well as in our actions we aim to be sensitive to those who are suffering. We affirm the value of life and we are strongly opposed to euthanasia.

Morag Mylne
Convener, Church and Society

In 1994 the Board of Social Responsibility of the Church of Scotland submitted to the General Assembly a Study Group report on “Euthanasia – A Christian Perspective”.

Deliverance 16 of the General Assembly (1994): *Commends the Report on Euthanasia to the Church to facilitate informed discussion, opposes the introduction of legislation on Euthanasia, abhors its practice, and rejects the principles on which it is proposed, commends palliative medicine and hospice care, encourages further discussion on the legal and medical issue, and instructs copies of the report to be circulated to enable the Assembly's views to be known.*

In 1997 the Church of Scotland published an updated version of the 1994 report to the General Assembly “Euthanasia – a Christian perspective”.

Previous deliverances from the General Assembly have read as follows:

(1977) *While seeing no virtue in the prolongation of dying we (The General Assembly) are aware of no theological difficulty in allowing a patient in extremis to die naturally, disapprove of the deliberate termination of life, and see the alternative as “good terminal care”. (We) believe that legislation on the subject of euthanasia would be difficult to frame, interpret and enforce and would be open to unfortunate projections. It would be unacceptable to many doctors and would make for unhappy relationships in homes and hospitals for the aged and long term disabled. (We) call upon Christians to seek alternatives to euthanasia in adequate concern for those whose life has become burdensome by reason of age and illness.*

(1981) *The General Assembly re-affirms the view consistently held, that the Christian recognises no right to dispose of his own life, even though he may regard those who*

commit or attempt to commit suicide with compassion and understanding rather than condemnation. On the same basis of the Christian belief in God's sovereignty over life, there can be no support for the concept of permissibility in law to kill a fellow human being even if he requests it.

At the time of the first publication in 1994 of the Report on Euthanasia, the House of Lords Select Committee on Medical Ethics had just reported and the first words of their report were, "*There should be no change in the law to permit euthanasia.*"

Their Lordship's report, published and accepted by the Government¹ contains conclusions and recommendations which may be summarised as follows and these will form the basis of this present 2007 review of developments in the last decade and comment where indicated.

- 1) There should be no change in the law to permit euthanasia.**
- 2) A competent patient's right to refuse consent to any medical treatment is strongly endorsed.**
- 3) If an individual refusal of treatment by a competent patient is over-ruled by the court, full reason should be given.**
- 4) The development and growth of palliative care services is strongly recommended.**

For many people palliative care is associated exclusively with the terminal care of cancer patients, the control of pain, of other symptoms, and of psychological, social, and spiritual problems being paramount. The Scottish Partnership Agency for Palliative and Cancer Care in 1994 developed consensus guidelines involving all the professions contributing to the partnership between the health service and the voluntary sector.²

In 1990 the World Health Organisation defined palliative care as "the active total care of patients whose disease is not responsive to curative treatment.", and it was recognised that this definition covered many other medical conditions where end-of-life care implicitly involves the support of the patient and his family, in order that he may live as positively as possible in the time that remains to him. This concept of "Quality of Life" has been used in various branches of medicine, though it is a much broader issue with some conditions than when restricted to malignant disease.

The Scottish Partnership for Palliative Care in November 2006 reported on the findings of extensive consultation over a three year period throughout Scotland into the palliative care needs of people without cancer. This recognised the palliative care needs of patients with cystic fibrosis, dementia, heart failure, HIV/AIDS, motor neurone disease, multiple sclerosis, muscular dystrophy, Parkinson's disease, renal failure and respiratory failure. Dr Harry Burns, Chief Medical Officer for Scotland, addressed the challenges of

implementing the report's conclusions, which he welcomed as important goals for organisations and health care teams.³

There are however factors, that in recent years, have diminished the effectiveness of palliative care services, where end-of-life care is very much the domain of the generalist and not the specialist. Hospices provide a high level of specialist care, but receive limited NHS funding as palliative care is not a priority and they therefore rely heavily on charitable giving. In the community the patient depends on nursing, general practitioner, and social services, but is mainly supported by relative and friends. Since 2004 the new General Practitioner contract has led to the relinquishing of out-of-hours responsibility and the former 'personal' doctor continuity of care for the dying patient. Palliative care is rated very low in the Quality and Outcomes Framework of the new GP contract.⁴

5) 'Double effect' is not a reason for withholding treatment that would give relief if the doctor is acting in accordance with responsible medical practice with the object of relieving pain or distress and without the intention to kill.

The so called 'double effect' is based on the principle that the giving of a drug to relieve one symptom may cause other adverse effects. Drug interactions are widely recognised and are fully listed in the British National Formulary. Some of these are potentially hazardous, and those related to opioid analgesics are included.

The myth that giving morphine to relieve pain has the 'double effect' of accelerating the dying process has often been argued by those favouring euthanasia. Evidence over the past 20 years has repeatedly shown that, used correctly, morphine is well tolerated and does not shorten life or hasten death. Its sedative effects wear off quickly and it has a wide therapeutic range.⁵

Indeed morphine reduces stress even in the absence of pain and may prolong life by virtue of making it more tolerable.⁶

Opioid analgesics are used to relieve moderate or severe pain, and morphine is the most useful of these drugs. In the management of pain the dose of morphine is adjusted to the needs of each patient, while at the same time helping the emotional, psychological and spiritual distress which may aggravate pain. Some 20% of patients with cancer do not develop pain, and of those who do develop pain it can be well controlled in over 80% of patients.

In specialist palliative care it is recognised that chronic pain is continuous, and therefore regular analgesic dosage is required. The Cancer Pain Relief Programme of the WHO advocated the three step 'analgesic ladder'. When required morphine dosage is gradually 'titrated' to meet the patient's needs, and with gradual increase there is no maximum dose for morphine. Many patients maintained on high dosage morphine remain active and mentally alert. On the other hand if a doctor acts precipitously in administering a high dose of morphine, often given intravenously, then there is a risk of killing the patient.

- 6) Treatment limiting decisions should be made jointly by all involved in the care of the patient on the basis that treatment may be judged inappropriate if it will add nothing to the patient's well-being as a person.**

The difficulties for health care professionals when faced with communicating difficult choices to patients and their families is always present. While trying to promote patient autonomy the patient can be overwhelmed by a multitude of facts and alternatives relating to treatment. It is well known that a patient will only take in a small amount of this information. The relatives may understand more but will inevitably adopt a 'protective' attitude regarding the patient.

Success in such joint decision making is dependent on trust between the patient and relatives and the medical professional. If trust has been established by good communication from the first encounter, then later agreement on joint decisions is facilitated.

- 7) Definition of Persistent Vegetative State (PVS) and a code of practice relating to its management should be developed.**

Persistent Vegetative State (PVS) is a term that was first introduced in 1972 by Jennet and Plum to describe the clinical condition resulting from loss of function in the cerebral cortex, most commonly resulting from a severe head injury. This was subsequently reviewed a quarter of a century later by B. Jennet in 1997 when a number of definitive guidelines had been produced.⁷

A recent Vatican document on patients in a vegetative stated that tube-feeding such patients presumed to be near death was "ordinary" care and should not be discontinued because the patient still had human dignity. This reaffirmed an earlier Vatican ruling in 2004 that "The administration of water and even food by artificial means is, in principle, an ordinary means of preserving life". The aim of such nourishment was to "prevent death by starvation and dehydration".⁸

- 8) Development and acceptance of the idea that, in certain circumstances, some treatment may be inappropriate and need not be given, should make it unnecessary in future to consider the withdrawal of nutrition and hydration, except where its administration is in itself burdensome to the patient.**

Some health professionals regard the provision of artificial nutrition and hydration as basic care which should always be provided unless the patient's imminent death is inevitable, in which case the benefits may no longer be proportional to the burdens. There has been considerable debate over the last decade on the subject of hydration. The ethical, legal and medical dangers of a regime of sedation without hydration in the dying has been reviewed in a 2005 publication "No water-No life: Hydration in the Dying"⁹

This question came into sharp focus in the ‘Bland case’ where a young man (Tony Bland) was left in a persistent vegetative state (PVS) following a severe head injury and his carers obtained permission from the House of Lords to stop his artificial feeding.¹⁰

In the ‘Bland case’ Lord Lowry expressed his view as, “I do not believe that there is a valid distinction between the omission to treat a patient and the abandonment of treatment which has been commenced, since to recognise such a distinction could quite illogically confer on a doctor who had refrained from treatment an immunity which did not benefit a doctor who had embarked on treatment in order to see whether it might help the patient and had abandoned the treatment when it was seen not to do so.”

Lord Goff expressed his view that, “There is overwhelming evidence that, in the medical profession, artificial feeding is regarded as a form of medical treatment; and even if it is not strictly medical treatment, it must form part of the medical care of the patient.”

Artificial nutrition and hydration have been considered as medical treatments by the British Medical Association (BMA) since 1992. Subsequently the BMA ethics committee in 1999 proposed that the withdrawal of artificial nutrition or hydration from incompetent patients should not just be possible for patients in PVS but should also be an option for patients who have suffered a “serious stroke or have severe dementia”.¹¹

This raises the much broader question of whether nutrition and hydration are regarded as medical treatment or general care of patients in hospital – particularly the elderly, the disabled or confused patients. If it is medical treatment then the requirement is for adequate and appropriate food and liquid administration to be supervised by a health care professional.

If it is general care then there is a risk that it may be argued that it is the responsibility of the patient and their ‘human rights’ to take or refuse what is provided.

9) Treatment limiting decisions should not be determined by resource considerations.

Interventions can become inappropriate over-treatment if they result only in disease related and iatrogenic harm to the patient. Untimely referral to a hospice or overuse of interventions inconsistent with preferences and prognosis increase the likelihood of inappropriate clinical intervention. Patients should not have to forgo curative treatments to have access to palliative care, nor should they have to forgo palliative care just because they are still undergoing curative treatment. Care should be focused on maintaining the patient’s dignity and supplying effective palliation. Recommending palliative and hospice care is a seriously underused strategy for dealing with the overtreatment of terminally ill patients.¹²

10) Rejection of euthanasia as an option for the individual entails a compelling social responsibility to care adequately for those who are elderly, dying or disabled.

A commissioner for the Disability Rights Commission has commented “A right to die? I’m more concerned that everyone has the right to live.” In a culture which expects that modern medicine will keep people healthy and fit, there is the dread that any impairment may reduce physical or mental capacity. The main concern is about the message that euthanasia is a preferable solution for people who are severely incapacitated or in pain.¹³

There are deeply held prejudices about the quality of life of people with so-called terminal illness. A considerable volume of literature exists on the subject and Edlund and Tancredi postulated five different meanings of ‘quality of life’. They suggested that the meaning is dependent on the user of the term, on his understanding of it, and on his position and agenda in the social and political structure.¹⁴

When the patient’s life is limited and he has some awareness of this, his needs and concerns are highly individualistic, not readily amenable to measurement or estimate by observers. Even the MacAdam assessment of suffering – covering the patient’s symptoms; spirits; knowledge; and support – is of limited value. His quality of life is determined by the extent to which he has come to terms with his condition and is at peace with himself. This is also dependent on the family, social, and spiritual support that is provided for the patient.¹⁵

The need to ensure that the finite resources of the National Health Service are most efficiently used led to the idea of the QALY or ‘quality adjusted life year’. This is a means of finding the most cost beneficial use of resources which incorporates both life expectancy and quality of life. While the concept of the QALY is of importance in health economics, it impinges on the individual patient only in terms of the availability of services to that patient. Its use reflects the values and concerns of the community rather than those of the individual

11) Palliative care should be made more readily available.

The access to palliative care and curative resources are compounded by the distance from such facilities. The White Paper “Our health, our care, our say: a new direction for community services”¹⁶ makes scant reference to rural services, and failed to address rural services. Similarly the Kerr report for Scotland “Building a health service fit for the future”¹⁷ does not address the health inequalities in rural areas. Indicators of deprivation used to allocate resources by government agencies fail to capture the dispersed nature of rural disadvantage which characterises rural communities.¹⁸

The term ‘rural’ is filled with meaning and may be used to denote a society or culture; a different environment; a distinct kind of economy. While the characteristics of rural communities may differ the fact remains that at the last census 20% of the population of Scotland, nearly 1 million people, live in rural areas. Of this rural population some are

defined as “Accessible rural” living in settlements of less than 3,000 population and within 30 minutes drive of a larger town. But a quarter of a million people are defined as “Remote rural”, with settlements of less than 3,000 population and more than 30 minutes drive from a sizeable town.¹⁹

If overall health care gains are to be achieved, national planners should take note of this large subset of our population. The promotion of potentially higher quality centralised services may benefit urban populations, but compounds the health and social inequalities of rural populations who need to travel considerable distances to access those facilities. The problems of public transport further disadvantage those without cars. Furthermore rural and remote patients are less likely to have the opportunity to exercise choice, a central tenet of government policy.²⁰

12) Research into pain relief and symptom control should be adequately supported.

The problem of the treatment of intractable pain in terminal cancer was highlighted by Cicely Saunders in 1963.²¹ It was emphasised that an insufficient dose of an analgesic, or irregular timing of the next dose, produces loss of confidence which increases fear, dread and tension, thus requiring very much larger doses of drugs to control pain.

There have been considerable advances in the approach to pain management by Palliative Care professionals, and the development of new drugs and procedures in Pain Clinics. The major need is to ensure that this knowledge is disseminated to other health professionals and to patients. Good examples of this are the comprehensive “MIMS Handbook of Pain Management”, prepared by Napp Pharmaceuticals and available to all medical practitioners; and the similar publication “Control Pain: Live Life: A guide for patients in chronic pain” prepared in conjunction with Nurse Specialists in pain management.

Pain relief is closely associated with the relief of other symptoms – some amenable to medication, such as the relief of constipation - and others associated with anxiety and social or spiritual causes requiring quite different management. It is misleading to speak of the relief of ‘suffering’ by pain control, when suffering is existential and may have multiple causes.

13) Training of health-care professionals should prepare them for ethical responsibility.

The guidelines for Palliative Cancer Care were produced in 1994 “to facilitate the provision of palliative care so that it is available throughout Scotland, at the highest standards possible, to all those whose health and well-being can benefit from it.” These guidelines were developed by the Scottish Partnership Agency with the Clinical Resource and Audit Group and involved over a hundred health care professionals from various disciplines and agencies, together with patient representatives.²²

There is now a well developed body of knowledge in the field of palliative cancer care. The Guidelines provide the basis for education, training and staff support, and underpin the effective provision of palliative care by staff who can constantly refresh their attitudes, sharpen their skills or deepen their knowledge. The Scottish Partnership Agency for Palliative and Cancer Care brings together voluntary and statutory agencies.

14) Long term care of dependent people should have special regard to maintenance of individual dignity.

In a demographically ageing population the long term care of the elderly is in general an ever increasing challenge as most people will eventually have a ‘terminal illness’. Dame Cicely Saunders has said “All who reach old age are likely to endure a long period of dependence and often dementia.” Many people are haunted by the thought of a prolonged deterioration of all their faculties.

In the New Testament the word ‘dignity’ denotes a good opinion; an appearance commanding respect; honour. Individual dignity varies from person to person – it may involve never wanting to be seen without hair groomed and dentures in place; or a dislike of being referred to by first name; or not being asked their opinion while others discuss matters concerning the patient. How sad when only at a funeral or in an obituary we learn a fascinating history that nobody has bothered to elicit from the elderly person. It is encouraging to see the Annual Report 2007 for Highland Hospice is entitled “Dignity in Living”.

This particularly applies to psychogeriatric patients, suffering from disorders which may persist until death and may bring forward death. One in three die as a psychogeriatric inpatient, and their clinical and social characteristics may be such as to make it impossible for them to be cared for without the resources of a hospital. Their care is often prolonged and the maintenance of dignity and quality of life attained demands a commitment similar to that of hospice care.²³

15) Support is given to proposals for a new judicial forum with power to make decisions about medical treatment for incompetent patients.

16) Creation of a new offence of mercy killing is not recommended.

17) The recommendation that the mandatory life sentence for murder should be abolished is strongly endorsed.

18) No change should be made to the law on assisted suicide.

There is growing awareness that end-of-life care should aim at improving the quality of life of patients and their families through the prevention and relief of pain and other symptoms²⁴ The argument that without euthanasia or assisted suicide people will be forced to endure unbearable pain is fallacious as nearly all pain can be eliminated or

significantly reduced if proper treatment is provided. It is a national scandal that so many people do not get adequate pain control, but killing is not the answer to that scandal.

Over the last ten years the British pro-euthanasia lobby has used high profile cases of motor neurone and progressive supranuclear palsy to champion its cause in advocating “Dignity in Dying”. This changes the debate about “terminal illness”. Oregon’s assisted suicide law defines “terminal” as a condition that will “produce death within six months”, while the Dutch define “terminal” as a “concrete expectancy of death” with no absolute value.

One might argue that all humanity has a 100% expectancy of death. Under the new law in the Netherlands, unbearable suffering of either physical or mental nature has been a factor that qualifies one for induced death. The defeat of Lord Joffe’s “Assisted Dying for the Terminally Ill Bill” has led to the attempt to bring in euthanasia through a combination of “terminal sedation” and “living wills”. These attempts to change the law are completely opposite to the aims of Baroness Iora Finlay’s “Palliative Care Bill”, which seeks to improve access to good palliative care.²⁵

By definition euthanasia is a last act by a third party that intentionally causes a patient’s death, whereas in assisted suicide the person performs the last act with drugs provided by a doctor for the purpose of causing death. In a recent questionnaire survey of end-of-life decisions made by a random sample of 1000 British general practitioners and 1000 hospital specialists the anonymized responses showed that the proportion of UK deaths involving any form of doctor-assisted dying was extremely low (0.16%), and this combined with a relatively high rate of non-treatment decisions suggested a culture of medical decision making informed by a palliative care philosophy.²⁶

In the Netherlands, euthanasia, physician-assisted suicide, and other end-of-life decisions have been discussed for decades. Since 1991, Dutch physicians have had to report all cases in which they administered or supplied drugs with explicit intention of hastening a patient’s death. Reviews in 1995 and 2001 showed that the demand for physician-assisted death had not risen among patients and physicians, and physicians attitudes towards people’s rights to end-of-life decision making. The rate of physician-assisted suicide remains remarkably low compared with that for euthanasia. About one third of the physicians thought that euthanasia could be avoided by providing adequate palliative care to terminal patients. There was some increasing anxiety among physicians that economic measures are going to affect end-of-life decision making. In this survey ending life without the patient’s explicit request occurred in about 1% of deaths, most frequently among people dying at age younger than 65 years. This study does not take into account the unknown number of deaths not reported for legal assessment by the Public Prosecutor²⁷

The assumption that “dying with dignity” is achieved by lethal medication may in the event lead to a very undignified death. The Dutch guidelines for the implementation of euthanasia recommend that family members should not be present since the death may be

very unpleasant to observe. In one out of five cases of euthanasia or medically assisted suicide there are problems or complications.²⁸

19) The development of advanced directives is commended but legislation for advanced directives generally is considered unnecessary.

Many people are worried that serious illness may leave them 'kept alive' by medical technology. The British Medical Association says that while "life should be cherished despite disability and handicaps", it should not be "indefinitely sustained in all circumstances, for example when its prolongation by artificial means would be regarded as inhumane and the treatment itself burdensome"²⁹

It has been noted above from the House of Lords report, 1993 that "a competent patient's right to refuse consent to any medical treatment is strongly endorsed."

While a patient's wishes may be competently expressed at the time of writing an advanced directive there may be other considerations when the time arrives. It is not unknown for a patient for a patient to change his or her mind. Relatives may hold different views, and this then raises the question of 'proxy' decisions. The greater awareness that clinical judgement is not infallible, and increases greater pressure on health professionals to protect their own as well as their patient' best interests.

In considering the ethical implications of advance directives, Macritchie has written, "My concern is that, as the sheer numbers of elderly people increases, and as precedence pushes more and more on the boundaries of acceptability, solicitude will decrease proportionately. Then, on the one hand, people may be kept alive beyond propriety (and the difficulty of defining such a parameter is acknowledged) or, of perhaps greater concern, people may be kept alive simply through a deficit of solicitude on the part of their carers."³⁰

20) A code of practice on advanced directives should be developed.

The "Mental Capacity Act" 2007 introduces legally binding 'advance directives'.

21) There should be no more widespread development of a system of proxy decision-making.

DEVELOPMENTS *SINCE* SECOND EDITION

United States of America

4/99: Jack Kevorkian receives 10 -25 years in prison for the second degree murder of Thomas Youk, 52, a patient with Lou Gehrig's disease. The administration of the lethal injection to Youk was videotaped and broadcast on television. Kevorkian was released in 2007.

5/99: A Florida woman left paralysed from the neck down after being shot by her elderly mother wins the right to be taken off life support and dies the next day, shortly after the ventilator is withdrawn. Her mother is later acquitted of attempted murder.

11/00: Maine narrowly rejects Death with Dignity Act by 51% - 49%.

2/02: Oregon Health Division statistics on assisted suicides show 44 people received prescriptions for lethal medication in the previous year but only 21 actually took their lives.

4/02: District Judge upholds Oregon's assisted suicide law and says that Attorney General should not "determine the legitimacy of medical acts." This is upheld in the Supreme Court in 2006.

3/05: Terri Schiavo dies 13 days after her feeding tube is removed. She had been brain damaged since 1990 when, aged 26, her heart stopped beating temporarily and oxygen was cut off to her brain. In 1998, her husband Michael Schiavo filed a petition to have her feeding tube removed. Seven years of legal battles ensued between Michael Schiavo and Terri's parents, the Schindlers. After a Florida Circuit Judge ruled that Terri Schiavo's feeding tube be removed and the Florida Supreme Court overturned "Terri's Law," a law intended to reinsert the feeding tube, the United States Supreme Court refuses for the sixth time to intervene in the case.

1/06: Supreme Court upholds Oregon's Death with Dignity Law by 6-3 opinion.

Netherlands

4/01: Euthanasia is legalised.

9/03: An amendment to Article 293 of the Criminal Code regarding the termination of another person's life shall not be an offence if it is committed by a physician who notifies the municipal pathologist of this act in accordance with the relevant legislation.

Switzerland

98: Ludwig Minelli founds Dignitas, a physician assisted suicide organisation for foreigners. Euthanasia had been legal since 1942.

Belgium

5/02: Parliament approves bill that gives terminally ill right to die under certain limited conditions.

9/03 Belgium has also established a system of control, whereby the physician has to declare the act of euthanasia to a Federal Evaluation and Control Commission.

United Kingdom

12/99: Following concerns that clauses in the Adults with Incapacity Bill amounted to a form of euthanasia, Deputy First Minister Jim Wallace said: "A recurrent theme has been the implication that, in some way or another, the bill opens the way to passive euthanasia. I want to make the position absolutely clear. The Scottish Executive is totally opposed to euthanasia. Any such act is a crime in Scotland and nothing in the bill is designed to alter that position".

11/04: A Member's Debate held in the Scottish Parliament - noting that a House of Lord's Committee is considering "physician-assisted dying and euthanasia", and claiming 82% opinion poll support for the right to choose "to seek help to die with dignity" - calls for a "wide debate on end of life issues". Rhona Brankin, Deputy Health Minister, said "Under Scots law, an act of euthanasia by a third party, including physician-assisted suicide, is regarded as the deliberate killing of another and would be dealt with under the criminal law relating to homicide. The consent of the victim would not be a defence and no degree of compassion on the part of the person who carried out the act would amount to a legal justification"; she added that the then Executive had no plans to change the law.

1/05: Nine leading figures representing the major UK faith groups spoke out against Lord Joffe's proposed legislation whereby the terminally ill would be able to choose to die and then receive help to commit suicide. In an open letter to both Houses of Parliament, the religious leaders condemned the bill, saying: "Assisted suicide and euthanasia will radically change the social air we all breathe by severely undermining respect for life"..

10/05: Jeremy Purvis MSP lodges a proposal for an "Assisted Dying" Bill at the Scottish Parliament; it fails to receive sufficient support to be debated.

5/06: Lord Joffe's *Assisted Dying for the Terminally Ill Bill* is rejected in the House of Lords by 148 to 100. He says that he will bring it back, but has not yet done so.

2/08: Robert Cook, 60, suffocated his wife of 29 years with a plastic bag after she took an overdose; Vanessa Cook had worsening multiple sclerosis and had written of her wish to die. Her husband received a 12-month suspended sentence, after pleading guilty to manslaughter on the ground of diminished responsibility. The judge called it an exceptional case.

3/08: Jeremy Purvis tabled a motion in the Scottish Parliament: welcoming advances in palliative care and "national campaigns to allow patients to be aware of choices that they can make about their treatment", but "there remain patients who wish to

have greater control of their treatment and that it is right to debate allowing greater legal support for the choices that some patients may make to ask for assistance to die as they come towards the end of their terminal illnesses".

¹ House of Lords report, 1993

² Palliative Cancer Care Guidelines; 1994; HMSO

³ *Joined up thinking; Joined up care*; Scottish Partnership for Palliative Care; December 2006

⁴ *The Demise of Palliative Care*; R.Charlton; British Journal of General Practice; March 2007

⁵ *Double effect is a myth leading a double life*; Claud Regnard; Brit.Med.J; March 2007

⁶ *Hospice care in motor neurone disease*; TD Walsh , M Smith , & DH Summers ; Brit.Med.J; 1976;ii:605

⁷ *A quarter century of the vegetative state: an international perspective*; Journal of Head Trauma Rehabilitation; 12, 1-12

1991 - *Working Party Report on withdrawing life supporting treatment from patients in a vegetative state after acute brain damage*; The Institute of Medical Ethics; Lancet; 337, 97-8.

1993 - *Guidelines on treatment decisions for patients in the persistent vegetative state*; British Medical Association Annual Report; Appendix 7.

1996 *Working Group report on the permanent vegetative state*; Journal of the Royal College of Physicians of London; 30, 119-21

⁸ Vatican City (Reuters); 14 September 2007

⁹ *No water-No life: Hydration in the Dying*; Craig; Fairway Folio; Ed.

¹⁰ Airedale NHS Trust v. Bland (1993) 1 All ER 821

¹¹ *Withholding of Withdrawing Life-Prolonging Medical Treatment – Guidance for Decision Making*; British Medical Association Ethics Committee report 1999; Section 21.4

¹² *Defining limits in care of terminally ill patients*; U Braun & others; Brit. Med.J; 2007; 334: 239-241

¹³ *Comment*; Jane Campbell; The Times 2nd December 2004

¹⁴ *Quality of life; an ideological critique*; M Edlund & IR Tancredi; Perspect.Biol.Med; 1985; 28: 591-607

¹⁵ *An initial assessment of suffering in terminal illness*; DB MacAdam; Palliative Medicine; 1987; 1: 37-47

¹⁶ Department of Health, 2006

¹⁷ NHS Scotland, 2005

¹⁸ *Rural Scotland: an overview*; JM Bryden in *God's Own Country*; Church of Scotland Mission & Discipleship Council 2007

¹⁹ *Social Focus on Urban and Rural Scotland*; Scottish Executive; 2003

²⁰ *Poor access to care: rural health deprivation*; AG Baird & N Wright; Brit J of General Practice; August 2006; 567-568

²¹ Proc. R.S.M. 1963; March; 195

²² *Palliative Cancer Care Guidelines*; The Scottish Office, Home and Health Department; 1994

²³ *Slow euthanasia? The deaths of psychogeriatric patients*; D Black & D Jolley; Bri .Med J; 1990; 300: 1321-1323

²⁴ *Palliative care: a World Health Organisation's global perspective*; Sepulveda C. & others; J Pain Symptom Management; 2002; 24: 91-96

²⁵ *Euthanasia and Assisted Suicide: Frequently Asked Questions*; RL Marker & K Hamion; International Task Force on Euthanasia and Assisted Suicide; 2001.

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²⁶ *National survey of end-of-life decisions made by UK medical practitioners*; C Seale Palliative Medicine 2006; 20:3-10

²⁷ *Euthanasia and other end-of-life decisions in the Netherlands in 1990, 1995 and 2001*; BD Onwuteaka-Philipson & others; The Lancet; 2003 online June 17; 1-5

²⁸ *Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands*; JH Groenwoud & others; New England Journal of Medicine; 2000; 24 February: 553-555

²⁹ *Medical Ethics Today*; Brit Med J; 1993; 165

³⁰ *Advance Directives – the Ethical Implications*; I Macritchie; Scottish Journal of Healthcare Chaplaincy 1999; 2 : 8-10

Euthanasia: A Christian Perspective - Supplement, 2008

Also available:

Euthanasia: A Christian Perspective

First published in 1995 on behalf of

The Board of Social Responsibility of The Church of Scotland.

Updated and reprinted in 1997.

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Charity Number: SC011353