Consultation on Proposed Assisted Dying for Terminally Ill Adults (Scotland) Bill
Response by the Free Church of Scotland

About You

The Free Church of Scotland is a Christian church with a network of around 100 congregations all across Scotland and over 13,000 of us gather at services every week to worship God, but our Christian faith affects all of our life, not just a Sunday at church. Our ministers and others are regularly involved in pastoral care which includes accompanying people in the final stages of their life and supporting grieving families and friends – our experiences in this area provide important insights into issues around living and dying well. We also have many members involved in healthcare and caring professions, including end of life care and we have drawn on their experience in preparing our response to this consultation.

Responses to the Consultation Questions
Aim and approach

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

~~**Fully supportive**~~

~~**Partially supportive**~~

~~**Neutral (neither support nor oppose)**~~

~~**Partially opposed**~~

Fully opposed

~~**Unsure**~~

Please explain the reasons for your response.

The Free Church of Scotland welcomes the opportunity to contribute to the public debate on matters surrounding assisted dying. We agree with Liam McArthur that it is vital as we emerge from the pandemic that we seek as a society to "create a new standard for how we die". There is a need for much greater investment in palliative care for those facing death and support for their family and friends. A truly compassionate and just society would recognise that all life has intrinsic value and dignity – regardless of our circumstances. It would seek to do all that we can to care well for the whole person.

A proposal for "assisted dying" should seek to address all of the many complex needs surrounding end of life care. However, Liam McArthur's proposal is wrongly focused exclusively on what should be called "assisted suicide". It is true that introducing assisted suicide into law would "create a new standard for how we die", however, it would be a move in the wrong direction – a move away from excellent palliative care towards involving healthcare professionals in killing patients. It would result in a huge amount of pressure being placed on the most vulnerable in our society to end their lives. It would result in a more unjust society.

As a Christian church we are called to speak up for the vulnerable in our society (Proverbs 31:8-9) and accordingly, we cannot be silent but must speak clearly to warn of the inevitable harms associated with these proposals. We are fully opposed to the proposals for the following reasons:

1. The Inherent Value, Worth & Dignity of Every Human Life

As a Christian Church we believe that human beings are made in God's image and likeness and this gives an inherent dignity, worth and value to each one of us. As Christians, while we recognise that not everyone will share our beliefs on the origin of human dignity, we would point out that the inherent dignity of every human being has also been recognised internationally. For example, the Universal Declaration of Human Rights begins with these words:

"Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world…"

Proposals for assisted suicide fundamentally undermine this principle. They make clear that society no longer believes that certain lives are worth living. We believe that the principle of universal human dignity demands that we treat human life with the utmost respect and this prohibits the deliberate ending of an innocent human life, including one's own. It also prohibits assisting others to end their own lives.

Our responsibility is to protect human life, especially at its weakest and most vulnerable, and our humanity is best shown in our mutual care for one another to reduce suffering and to give appropriate support right up to the end of life. This includes making palliative care available to all who would benefit from it. It does not demand that we attempt to prolong life indefinitely by burdensome treatment when no long-term benefit is achievable but that is completely different from assisting someone to end their life. It is also not true that allowing assisted suicide increases human dignity at the end – in fact a significant number of assisted suicides result in complications[1].

Human dignity, worth and value are not dependant on our circumstances, and it is right as a society that we do care for those who cannot fully care for themselves. At the beginning of life young children need our care and support and that same care should be available at the end of life. The proposals in this bill would send a clear signal that some lives are no longer worth living.

2. Undue Pressure on Sick and Vulnerable People

Introducing proposals to allow assisted suicide would place a great deal of pressure on sick and vulnerable people to end their lives out of the fear of becoming a burden. As someone who is dying sees the amount of care they require from family and friends they may conclude it would be better if they simply ended things quickly to remove the burden. No human is an island, and we all need help from one another from time to time and so it is right that we care for those at the end of life. The problem is that as individuals we often find it harder to accept care than we do to offer care, making it difficult for vulnerable people to cope when they feel they are a burden on those they love.

Moreover, there is pressure not to become a burden to the health service. In society we are rightly grateful for the benefits of the NHS. But we also know it is under-resourced and we don't want to become a drain on those resources. During the Covid-19 pandemic we acted as a nation to protect

[1] See for more information J H Groenewoud *et al*, "Clinical problems with the performance of euthanasia and physician-assisted suicide in The Netherlands" *N Engl J Med*. 2000 Feb 24;342(8):551-6.

the NHS but sometimes that meant patients delaying or not going to healthcare professionals. A similar desire not to be a burden to the NHS could lead to people choosing assisted suicide rather than treatment and this is fundamentally wrong. We should encourage people to receive the care that they need.

None of the jurisdictions allowing assisted suicide collect or report the data necessary to determine if people choosing to consider 'assisted dying' are safe from abuse and coercion.

There would also be a major mental health risk among relatives of those who undergo assisted suicide as they ask themselves what did they do wrong to force their relative to conclude suicide was the only option.

3. Change to Patient / Doctor Relationship

The proposals would fundamentally alter the patient / doctor relationship. The first principle of medicine is to do no harm. There is an over-riding duty of care. But introducing proposals to allow healthcare professionals to be involved in assisted suicide would alter this relationship and in some cases erode public confidence in the healthcare profession.

4. Undermines Palliative Care

Proposals to introduce assisted suicide fundamentally undermine or devalue excellent palliative care. There is increasing international evidence from jurisdictions where physician assisted suicide and/ or physician administered euthanasia are legal, that there is a significant negative impact on palliative care[2]. For example, Canadian hospices are told to deliver 'medically assisted deaths' or lose their statutory funding. Where there is less need for palliative care due to assisted suicide there is less incentive on healthcare professionals to develop better palliative care.

5. Open to Abuse

There are many reports of abuse where assisted suicide has been introduced in other parts of the world[3]. There could never be sufficient safeguards to prevent abuse occurring.

6. Contradicts Work to Prevent Suicides

Suicide prevention is a hugely important area of work. The Scottish Government has rightly made clear in their "Suicide prevention action plan: every life matters" that: "no death by suicide should be regarded as either acceptable or inevitable." Suicide is a tragedy and many throughout our nation do excellent work to reduce suicide. Introducing assisted suicide contradicts this work and gives the clear message that there are certain circumstances where suicide is the best option. We must not give such a harmful message to our society.

7. An Incremental Extension of Assisted Suicide

While the desire of the legislative proposal is to limit assisted suicide to certain clearly defined categories the experience in other jurisdictions has been clear incremental extension of assisted

[2] SM Gerson e*t al. "*Assisted dying and palliative care in three jurisdictions: Flanders, Oregon and Quebec" *Annals of Palliative Medicine*, 2020

[3] See for example the many cases listed at https://dredf.org/public-policy/assisted-suicide/some-oregon-assisted-suicide-abuses-and-complications/

suicide into other categories including children and those suffering from mental health concerns[4]. There is also evidence of a huge increase in the number of people receiving assisted suicide. Liam McArthur rightly desires to limit the application of assisted suicide but no parliament can bind a future parliament and once the Rubicon has been crossed by introducing assisted suicide it is much easier to extend it to other areas.

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.

We do not believe the legislation is required. Instead, we should seek to become a more compassionate society by investing in more holistic palliative care as the best means of achieving dignity in dying. The word 'compassion' comes from Latin and means 'suffering with' – walking alongside someone through suffering. The compassionate approach is to provide better end of life care but not to simply seek to end the person's life.

We note the consultation document is not satisfied with the vagueness of the Scottish approach to assisted suicide, however, we believe the current law strikes the right balance. The law rightly declares that it is wrong to assist someone to end their life but also shows compassion and mercy to those who have done so by usually not prosecuting as it is not in the public interest. This does allow prosecutors to prosecute a case where they believe it is in the public interest, for example where there was abuse. In our view this gets the balance right.

In terms of achieving the aims of the legislation through others means we would make the following comments.

The experience of those involved in end-of-life care is that most care is excellent – physical suffering and other symptoms can be effectively addressed in up to 95% of patients, with appropriate medication, when treated by healthcare professionals with the relevant expertise. Scottish Palliative Care Guidelines are a helpful resource – the biggest challenge is proper resourcing of palliative care. The objective of improving end of life care could be achieved by increasing palliative care resources. In particular it would be helpful to ensure people can access the correct care without delay, no matter where in Scotland they might be based.

All hospices are currently run by charities and are always in need of more support. The NHS should provide more funding for hospice care. In addition to this more funding should be provided for palliative care nurses who can help where patients are based further away from hospices. General nursing staff can also be given more training in relation to palliative care.

There are occasional cases which are extremely complex and require expert input. Work should be done to ensure nurses have quick access to experts when things are not going well.

It is also important to provide emotional and spiritual support to those facing a terminal diagnosis and their family and friends. It is vital that their fears are managed through providing clear information at an early stage of diagnosis and helping them to make a plan together.

More generally work can be done to educate the general public about death and palliative care to help take away some of their fears and misunderstandings.

[4] See for example the Canadian experience – Tom Koch, "MAID's slippery slope: a commentary on Downie and Schuklenk" *Journal of Medical Ethics* 2021;47:670-671.

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)?

~~**Fully supportive**~~

~~**Partially supportive**~~

~~**Neutral (neither support nor oppose)**~~

~~**Partially opposed**~~

Fully opposed

~~**Unsure**~~

Please explain the reasons for your response, including if you think there should be any additional measures, or if any of the existing proposed measures should be removed. In particular, we are keen to hear views on Step 2 – Reflection period, and the length of time that is most appropriate.

We fear the process is all too mechanistic and dehumanising. It gives the wrong impression that this is a simple process to follow, when in reality it would be incredibly traumatic for both the patient and family and friends.

A 14 day reflective period sounds like a sensible safeguard, however, it fails to take account of the fact for many the decision over that 14 day period will go back and forth as people wrestle with such a difficult decision. What happens if at day 14 the person has decided not to go ahead and then changes their mind on day 15?

We also note that nothing in the process explains what will happen if there are complications after the drugs are delivered. In the Netherlands around 7% of cases involve complications[5]. How is the healthcare professional to deal with such complications?

We are also concerned about what happens if the patient suddenly changes their mind after taking the drugs to end their life. What is the role of the healthcare professional at this point. Are they to take steps to try and save the patient's life? Can they easily switch between the role of assisting with suicide to seeking to preserve life?

We also note there is no reference to what support is given to friends and family during the process nor what their role is in the process.

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

~~**Fully supportive**~~

~~**Partially supportive**~~

~~**Neutral (neither support nor oppose)**~~

[5] See for more information J H Groenewoud *et al*, "Clinical problems with the performance of euthanasia and physician-assisted suicide in The Netherlands" *N Engl J Med*. 2000 Feb 24;342(8):551-6.

~~**Partially opposed**~~

Fully opposed

~~**Unsure**~~

Please explain the reasons for your response.

We take the view that the safeguards are completely inadequate and in fact there could never be sufficient safeguards to go ahead with these proposals.

In particular, we note that the primary safeguard seems to be the fact that two doctors will be involved in the assessing. However, we know that doctors are under an incredible amount of pressure and most of them will sign off such a process based on their colleague's assessment. We also note that while two doctors are involved in the process when it actually comes to the moment of prescribing and delivering the drugs only one doctor is involved. Who is to know if there is abuse at that point? What if the person is struggling to take the drugs – that one doctor may find themselves in the position of helping the person to take them. We are also concerned that this one doctor who is carrying out the assisted suicide is having to assess capacity, mood and family relations in an incredibly emotionally charged situation – this is a huge responsibility for any doctor.

Capacity is another safeguard. However, capacity is very difficult to assess and someone can have periods of capacity and periods when they lack capacity. Vulnerable people will be open to exploitation.

We also note the limitations of the application of the legislation are meant to be a safeguard. One of these is that the patient must have a terminal illness. But it is not always easy to decide when an illness is terminal, and we note the legislation proposes to use the broad definition of terminal illness that has been adopted in relation to benefit entitlement. While for benefits it is appropriate to have a broad definition to ensure as many people as possible are helped it is not appropriate to use that same definition when it comes to something as serious as assisted suicide.

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

~~**Fully supportive**~~

~~**Partially supportive**~~

~~**Neutral (neither support nor oppose)**~~

~~**Partially opposed**~~

Fully opposed

~~**Unsure**~~

Please explain the reasons for your response, including whether you think this should be a new or existing body (and if so, which body) and what data you think should be collected.

As we do not approve of the principle of assisted suicide we do not approve of the creation of this kind of body. However, we would also point out that the existence of such a body will not prevent abuse.

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

We fear that while some might be able to make use of a conscientious objection not every healthcare professional will feel this goes far enough. Presumably, GPs and others who object will still have to be involved in referring patients on for assisted suicide. Moreover, if assisted suicide becomes an accepted aspect of hospice care will some healthcare professionals find themselves excluded from positions in hospices because of their conscientious objection to assisted suicide? Will a healthcare professional who is asked to explain the various options to a patient always have to mention assisted suicide even if they will not be involved in its delivery? There are many unanswered questions surrounding conscientious objection.

Financial implications

7. 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:

~~**a significant increase in costs**~~

~~**some increase in costs**~~

~~**no overall change in costs**~~

~~**some reduction in costs**~~

a significant reduction in costs

~~**don't know**~~

Please indicate where you would expect the impact identified to fall (including public sector bodies, businesses and individuals etc). You may also wish to suggest ways in which the aims of the Bill could be delivered more cost effectively.

We believe that a move towards assisted suicide will save the NHS significant sums of money in not providing long term end of life care. The consultation document supports this in a footnote:

"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."

We already know that there are many areas of medicine where cost is taken into account – such as when prescribing cancer drugs which may only extend life by a short period of time. Someone has to make these financial decisions and usually this is carried out by managers rather than healthcare professionals. We are deeply concerned that there might be a financial motivation for allowing assisted suicide in the face of an under resourced health service. You cannot put a financial measure on human life.

Equalities

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?

~~**Positive**~~

~~**Slightly positive**~~

~~**Neutral (neither positive nor negative)**~~

~~**Slightly negative**~~

Negative

~~**Unsure**~~

Please explain the reasons for your response. Where any negative impacts are identified, you may also wish to suggest ways in which these could be minimised or avoided.

Legalising assisted suicide would completely undermine the equality in value and worth of all lives in Scotland. We are deeply concerned that this legislation will result in undue pressure being placed on the elderly and the disabled to end their life. We note the opposition to assisted suicide by a significant proportion of the disabled community[6]. These proposals fundamentally reduce the value we place on the elderly and disabled in our society – this cannot be right in a compassionate and caring society.

We also note with concern the fact that the consultation document states: "Research has shown that the lack of choice at the end of life disproportionately and detrimentally affects women who continue to be the primary care givers at the end of life." This suggests that a spouse caring for their spouse is not a good thing. As Christians we teach that marriage is for life, in sickness and in health and it is a good thing to care for your spouse when they are facing illness and suffering – this is in fact how love is best expressed in sacrifice for one another. The idea that this legislation might be brought forward to stop the need for such care is deeply concerning and suggests a departure from a caring society.

Sustainability

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:

- **living within environmental limits**
- **ensuring a strong, healthy and just society**
- **achieving a sustainable economy**
- **promoting effective, participative systems of governance**
- **ensuring policy is developed on the basis of strong scientific evidence.**

With these principles in mind, do you consider that the Bill can be delivered sustainably?

~~**Yes**~~

[6] See for example the work of Not Dead Yet (http://notdeadyetuk.org/)

No

~~**Unsure**~~

Please explain the reasons for your response.

We fundamentally believe the proposals in this consultation would result in a society that is more unjust and less compassionate. The proposals encourage autonomy which undermines the interconnected and interdependent aspects of our society. We all need to take steps to care for one another as our neighbours. These proposals undermine this.

General

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)?

We believe calling this proposal assisted dying is deeply misleading and results in inaccurate polls showing support for this. Many wrongly believe assisted dying covers palliative care and withdrawing of life prolonging treatment. Whereas the proposals are focused specifically on assisted suicide which actively involves healthcare professionals in promoting death.

The Free Church of Scotland is fundamentally opposed to assisted suicide – it devalues human life, places undue pressure on the vulnerable and is open to abuse and incremental extension. We believe life is a gift from God and those suffering deserve our compassion and care. Accordingly, we are committed to more palliative care and proper emotional and spiritual support for those facing death, and their loved ones.