End of Life Assistance (Scotland) Bill
Church of Scotland, the Methodist Church in Scotland and the Salvation Army

Introduction
This response to the Call for evidence on the above Bill has been prepared by the following Christian denominations:

**The Methodist Church in Scotland**: There are over 70 congregations and over 3 thousand Methodists in Scotland who are part of the Methodist Connection which has around 265 thousand members across the UK which is associated with 75 million Methodists around the world. Methodists are on a journey to follow in Jesus' steps. By care about society and the wider world that we all live in and by engaging with politics and society, Methodists live out our calling to love and hope.

**The Salvation Army**: The Salvation Army has 82 Corps/centres in Scotland with approximately 4500 members, and are part of the United Kingdom Territory with the Republic of Ireland. The Salvation Army is at work in 120 countries. The three-fold mission of the Salvation Army as detailed in its Mission statement is 'Called to be disciples of Jesus Christ, the Salvation Army in the United Kingdom Territory with the Republic of Ireland exists to save souls, grow saints and serve suffering humanity.'

**The Church of Scotland**: The Church of Scotland has around 984 active ministers, 1,179 congregations, and its official membership at approximately 489,000 comprises about 10% of the population of Scotland. In the 2001 national census, 42% of Scots identified themselves as ‘Church of Scotland’ by religion. The Church of Scotland seeks to inspire the people of Scotland and beyond with the good news of Jesus Christ through enthusiastic, worshipping witnessing, nurturing and serving communities

A number of people from each of these groups, many of them with professional expertise in areas relevant to this response, have contributed to the writing of this response.

This response includes two lines of argument:
First, it highlights arguments against assisted suicide in principle, and

Second, while not accepting the need to introduce such legislation, it highlights specific problems with the way this particular piece of legislation has been drafted.

1. Do you agree that a person should be able to request end of life assistance from a registered medical practitioner?

The Churches fundamentally disagree 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 attitudes to many aspects of health and social care, not simply for the determined few who are pushing for change.

The Churches reaffirm that an important aspect of their ministry is providing pastoral support to both individuals and communities, and particularly in
caring for the most vulnerable in society. On this matter we are clear that, while we are sympathetic towards the fears and desires of those who may be afraid of a painful death, what is proposed in this Bill is not the solution. Rather, there is a necessity to ensure that, as far as possible, all have access to good palliative care, which, 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.

**Autonomy:** One of the specific concerns about this Bill is that sometimes an individual may want to make a choice that is so damaging to the society in which we live that making that choice is wrong. Appeals to autonomy, while superficially seductive, fail to take into account the interconnectedness of communities, and the fact that the concept of a person being a burden to society is inimical to autonomy, as somebody who is truly autonomous by definition cannot be a burden.

**Dignity:** The term “dignity” is used loosely in the Bill, so that it is presented as an objective and clearly defined entity, embodied by assisted dying. Human dignity is a very complex but extremely important issue which cannot simply be reduced to the manner in which a person considers him or herself. It is also erroneous, and agenda-driven, to define dignity in care, and in dying, simply in terms of the availability of assisted dying. The issue of dignity in care and dying has been extensively explored in the medical literature. There is a necessity to accept that death is a natural process, and that not every death is a medical failure.

**What is a good death?** What is 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 perfunctory consultations, scrutiny of one’s mental health (with possible significant cost, as access to NHS psychiatrists is not normally available within the timescales required by the Bill). All this is required under the legislation to take place within a short time frame and without the opportunity to discuss hesitation or distress lest that should be interpreted as a revocation, at a time when life is already deemed to be intolerable.

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.

**Additional costs:** The Bill is clear that there are likely to be costs to the individual associated with seeking assisted suicide; it is therefore possible that such legislation would create a two tier system which would enable the wealthier to choose assisted suicide and leave the poor with the current arrangements. It would be more desirable to improve end of life care for all.

2. **Are you satisfied with the requirements for age and connection with Scotland as set out in the Bill?**

Our opposition to the Bill in principle notwithstanding, we believe it is entirely inappropriate that end of life assistance should be offered to a sixteen year old. It is not possible that a final and definitive judgement regarding the
intolerability of their life might be made by a person who has not yet achieved maturity, particularly when it is entirely accepted within the terms of the Bill that such a perception is necessarily subjective.

We are also concerned that the residency requirement of only eighteen months creates the possibility that persons may move to Scotland and register with a medical practitioner in order to seek end of life assistance.

3. Are you satisfied with the two categories of people who would qualify to be assisted under the terms of the Bill?

There is a fundamental difference between someone who is “terminally ill and finds life intolerable” and someone who is “permanently physically incapacitated to such an extent as not to be able to live life independently and finds life intolerable”. As there is no definition of “permanently physically incapacitated” and no definition of “live independently” there is ambiguity as to what is actually being legislated for and therefore it is difficult to comment on the categories of people who would qualify for end of life assistance under this Bill. There are strong arguments that could be made that no one is able to live independently; these are explored more fully in a subsequent question about safeguards.

There are many factors which may make life seem intolerable to a person. End of life assistance is not the best response to such a perception. The many factors, including the intense suffering of severe physical pain and perceived loss of dignity, can and should be addressed holistically.

The potential subjectivity and inaccuracy of a diagnosis of terminal illness is also not sufficiently recognised in the Bill. Indeed, some persons whose diagnosis is uncertain to at least to some degree would inevitably be allowed to proceed.

4. The Bill outlines a several stage consent and verification process that would be required to be followed for an eligible person to receive end of life assistance. Are you satisfied with this process?

We do not wish to respond to this question.

5. Do you consider the nature and level of safeguards as set in the Bill to be appropriate?

The safeguards in the Bill all relate to the individual who may seek assisted suicide, they do not relate to society. Human beings are essentially social; each of us is dependent on others for physical and spiritual survival and flourishing. It is impossible for a person to ask for assistance to end their life without that affecting their family and community. The safeguards included in this Bill focus only on the individual who may wish to end their life. Allowing legally assisted suicide would fundamentally affect the nature of the medical profession, it would fundamentally affect those who provide care for the sick and home help for the incapacitated, and it would fundamentally affect our society. The Bill does not, and to a large extent cannot, offer safeguards for the medical profession, for other care providers for example in residential care settings or home help and for society as a whole.

The value of human life is not determined by whether a person has the capacity to live unaided, nor need the quality of a life be diminished because a
person needs assistance, provided that the assistance provided is respectful, loving and appropriate to the needs of the recipient.

The Bill provides safeguards intended to check that the person “is not acting under any undue influence” when making the request. This is a subjective test as influence comes in many guises. The Bill makes explicit provision relating to people living in residential care, and in this environment the question of influence in especially complex. For example, if a resident of a care home seeks assistance to end their own life how this would affect other less able residents? It 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.

This legislation requires that members of the medical profession are active participants in the process of assisted suicide. It is agreed that there is a role for the medical profession to support people at the end of their lives; however, that role should not include the intentional ending of life. Requiring members of the medical profession to intentionally end life will fundamentally change the relationship between medical professionals and the society they serve. This is a point of principle that 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 be practical problems in rural areas where alternative practitioners may not be available.

The following headings could be explored in more detail:

How society understands / communicates / discusses death, dying and bereavement.

Avoidance of 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.

What about illnesses such as dementia in which there is minimal medical treatment / intervention but a high need for care, which may be expensive?

Rights of family members.

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.

Protection of the weak and vulnerable, people who cannot argue against being led down a particular route.

6. Do you have any other considerations on the Bill not included in the answers to the above questions?

The drafting of the Bill includes the possibility of euthanasia. We would urge that the possibility of euthanasia be explicitly prohibited.

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