End of Life Assistance (Scotland) Bill

Christian Medical Fellowship

Introduction
The Christian Medical Fellowship (CMF) is an interdenominational organisation in the UK with some 4,200 doctor members and over 1,000 medical student members. Of these, 421 doctors and 86 students are members in Scotland. All are Christians who desire their professional and personal lives to be governed by the Christian faith as revealed in the Bible. Members practise in all branches of the profession, and through the International Christian Medical and Dental Association are linked with like-minded colleagues in over 100 other countries.

CMF regularly makes submissions on ethical matters to Government committees and CMF Scotland submitted evidence to the Scottish Parliament in 2005 concerning Jeremy Purvis MSP’s Dying with Dignity consultation paper, and in 2009 to Margo MacDonald MSP’s consultation on the Proposed End of Life Choices (Scotland) Bill. Prior to the devolution of health matters to Scotland, CMF made a major submission to the 1993-1994 House of Lords Select Committee on Medical Ethics which considered euthanasia and related matters; and again in 2004 to the Select Committee of the House of Lords on the Assisted Dying for the Terminally Ill Bill.

CMF was a founder member of the Care Not Killing Alliance and is a member organisation within Care Not Killing Scotland.

We have also published widely on the subjects of euthanasia and assisted suicide – see our website at www.cmf.org.uk and in particular CMF Files on Euthanasia and Physician-assisted Suicide.

We thank the Scottish Parliament for this opportunity to comment on the current Bill, and now respond to the Committee’s specific questions:

Do you agree a person should be able to request end of life assistance from a registered medical practitioner?
No. Most religious faiths regard intentionally ending life as morally wrong. In Christianity, a fundamental principle is that unlike all the animals, human beings alone are made in the image of God and are therefore worthy of the utmost respect, protection, wonder and empathy.

The Sixth Commandment ‘You shall not murder’ prohibits the intentional killing of the legally innocent and this forms the basis for part of Christian medical ethics. It also forms the basis for law and legal practice on homicide, including that in Scotland.

‘Bearing one another’s burdens’ is at the very heart of Christian morality, and Christians are called to love others in the same way that Jesus Christ loved, which for him meant making sacrifices and willingly laying down his life for others.
So, rather than contemplating the taking of innocent human life, Christians are often at the forefront of providing the best quality care for patients who are terminally ill. Recognising the inevitability and often the rightness of natural death, Christians work against unnatural deaths and seek to practise a deep commitment to relieving human suffering legitimately.

This deontological opposition to assisted suicide and euthanasia is reinforced by all the consequentialist arguments against legalisation, some indicated in this brief Submission and all extensively detailed through our references. Our stance is therefore not just faith-based, but we are joined in opposition to legalisation by the World Medical Association (in its 1992 Statement of 

We strongly endorse BMA Scottish Council Chair’s recent statement that ‘if doctors are authorised by law to kill or help kill, they are taking on an additional role that we believe is alien to the one of care-giver and healer’.11

Are you satisfied with the requirements for age and connection with Scotland as set out in the Bill?
No. It will be clear from the above that we reject patients of any age as being ‘eligible’. While we understand why a lower age limit is included, the mention of any age at all implies subtly that euthanasia and assisted suicide are right for some. This we reject.

Regarding the connection with Scotland, registration with a medical practice for at least 18 months prior to the request would not rule out residents of other UK or indeed any other countries who had two homes; and given the impossibility of policing patient registrations, would not rule out the fraudulent applicant who really lives in another country. Having health powers devolved, Scotland must accept a corresponding responsibility to the citizens of other UK countries where the acts proposed are illegal and no legislation is pending.

Are you satisfied with the two categories of people who would qualify to be assisted under the terms of the Bill?
No. Regarding the ‘terminally ill’ person who ‘finds life intolerable’, defining terminal illness with a six month period may seem sufficient, but quantifying medical prognosis is notoriously inaccurate. In any case the attitudes and approach of professionals, and the quality of care provided, may well affect the length of life remaining.

There is no definition at all of what might constitute ‘intolerable’. The term is far too hazy and subjective. While palliative care must be discussed under the terms of the Bill, there is no requirement that a trial of palliative care be provided. It is the almost universal experience of the palliative care movement that behind a request to die lies another question – a previously unexpressed fear in the realm of the physical, the psychological, the social, or the spiritual – and that when that real need is met, the request is not repeated. This word
‘intolerable’ typifies the euphemisms and ambiguities that occur throughout the Bill.

This concern also applies to the second category, of the patient ‘permanently physically incapacitated to such an extent as not to be able to live independently and [who] finds life intolerable’. This group includes all who are to some extent dependent on others, and covers a very wide range of common conditions such as heart and lung disease and arthritis. Hundreds of thousands of seriously ill and disabled people throughout Scotland would fall within its remit. Providing for them an option to be killed might, by all sorts of subtle pressures, internal or external, become an obligation to be killed.

The Bill outlines a two-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?
No. The Bill contains no specified procedures by which the ‘designated practitioner’ or the ‘psychiatrist’ have to report their involvement with a case of assisted suicide or euthanasia. Investigation and audit would thus be impossible, in both medical but, more importantly, legal senses.

Do you consider the level and nature of safeguards as set out in the Bill to be appropriate?
No. They are seriously defective. Among others, it is unlikely that the superficial medical assessments proposed could discern every case of possible external pressure, nor assess that misplaced altruism which might lead many with chronic conditions to see themselves as a burden to family, caregivers, or State. The very existence of such an Act would send a strong message to hundreds of thousands of Scots (and others) that there is such a thing as a life not worth living, and the apparent safeguards laboured in the Bill are little more than camouflage for the underlying ethical error and the extreme proposals.

Do you have any other considerations on the Bill not included in answers to the above questions?
The euphemisms and ambiguities extend to: what is it in practice that the Bill is actually proposing? It is clear from the language of ‘the provision or administration of appropriate means’ and subsequent vagueness that the Bill is actually about both assisted suicide and euthanasia. For the avoidance of doubt, CMF sees no fundamental moral difference between acts of euthanasia and of assisted suicide, where (in the case of physician assistance) the suicide could not have proceeded without the expertise and legal powers of the physician to prescribe lethal medication. Assisted suicide is ‘euthanasia one step back’.

Further, considering the very wide range of potentially eligible patients who are not terminally ill, the Bill goes far beyond that which the Westminster Parliament has repeatedly rejected. At an earlier opportunity to discuss assisted suicide the Scottish Parliament has convincingly rejected legalisation.
The Bill contains no ‘conscience clause’. Given the controversial anti-Hippocratic nature of the underlying ethics, and the even more controversial practical proposals (to the extent that they can be discerned), many medical practitioners and many psychiatrists in Scotland would to our certain knowledge refuse absolutely to take any part whatsoever. To retain such doctors in practice a ‘conscience clause’ would be essential.

We emphasise that, in the absence of any specified process for reporting, there is no provision whatsoever for audit of any kind.

The Bill’s purpose at 1(2) is said to be ‘to enable a person to die with dignity and a minimum of distress’. This is what good doctors, nurses, other health professionals, and caring families and communities are already doing effectively, through palliative care in its widest sense.

**Conclusion**

Euthanasia and assisted suicide are both unethical and unnecessary – we do not have to kill the patient to kill the symptoms or to allow them to die with dignity. Euthanasia and assisted suicide can never be policed, when the key witness is dead. There is clear evidence that where voluntary euthanasia has been legalised and accepted, it has led to involuntary euthanasia. This was demonstrated in the Netherlands as early as 1990, where over 1,000 patients were killed without their consent in a single year.\(^12\)

A report commissioned by the Dutch government showed that for 2001, in around 900 of the estimated 3,500 cases of euthanasia, the doctor had ended a person’s life without there being any evidence that the person had made an explicit request.\(^13\) In addition, when it came to the reporting safeguard there was a huge gulf between the expectation of Dutch law and actual practice. For example, only 54% of doctors fulfilled their legal responsibility to report their actions concerning euthanasia. By 2005, medical practice in the Netherlands had formalised (non-voluntary) euthanasia for severely ill newborns.\(^14\)

We emphasise the Netherlands because the Bill is not ‘an Oregon-type’ one (assisted suicide only), as promoted by its advocates, but very much a ‘Netherlands-type’ one, with all of those proven consequences. Rather than the 50 people per year who would receive ‘end of life assistance’ if the Bill became law, as claimed by advocates, it is more likely that up to 1,500 Scots per year would have their lives ended in this way.\(^15\)

Unethical; unnecessary; impossible to police. Christian Medical Fellowship therefore calls upon the Scottish Parliament to reject this Bill absolutely at the first opportunity.

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11 May 2010
References

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2 Submission from CMF Scotland to Margo MacDonald MSP’s Consultation Document on the ‘Proposed End of Life Choices (Scotland) Bill’. www.cmfort.org.uk/publicpolicy/submissions/?id=59
3 Submission from CMF to the Select Committee of the House of Lords on Medical Ethics. www.cmfort.org.uk/ethics/submissions/?id=2
4 Submission from CMF to the Select Committee of the House of Lords on the Assisted Dying for the Terminally Ill Bill. www.cmfort.org.uk/publicpolicy/submissions/?id=4
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8 Exodus 20:13
9 Galatians 6:2
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13 Sheldon T. Only half of Dutch doctors report euthanasia, study says. BMJ 2003; 326:1164
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