Response ID ANON-RS6Y-1X5X-A

Submitted to Assisted Dying for Terminally Ill Adults (Scotland) Bill: Detailed Consultation – Call for Views
Submitted on 2024-07-23 10:47:50

About you

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Important information about responding to this consultation

I confirm I have read the information above and would like my response to be published in its entirety

What is your name?

Name:
Dr Richard Thomas

What is your email address?

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Are you responding as an individual or on behalf of an organisation?

Organisation

Organisation details

Name of organisation

Name of organisation:
Christian Medical Fellowship (CMF)

Information about your organisation

Please add information about your organisation in the box below:

CMF exists to unite and equip Christian doctors and medical students, nurses and midwives to live and work for Jesus Christ. It numbers about 4,500 UK members and is connected with over 100 similar organisations globally.

Question 1 - Overarching question

Which of the following best reflects your views on the Bill?

Strongly oppose

Space for further comment on your answer:

CMF recognises the good intention behind this Bill namely, to protect citizens in Scotland from
having to face a prolonged and painful death. However, we do not agree with the proposed solution.
A brief summary of our concerns includes:
• Definition – terminal illness is defined as a 'disease, illness or condition which they will not
recover from, is worsening and at a late stage, and which is expected to cause their
premature death.' We suggest that there are many medical conditions that would satisfy this requirement but that are not 'terminal' in the commonly understood meaning of that word. As it stands, this criterion is too 'elastic'
• Safety – in particular, that it is not a requirement to include routinely an assessment of
mental health, carried out by a qualified and experienced specialist. We suggest that one of the two assessing RMPs must be such a specialist, or that mental health assessment by a fully qualified specialist be included routinely
• Extension. The Bill appears to ignore experience in other jurisdictions, where assisted dying
has already been legalised and where its application has extended inexorably in both scope
and scale.
• Family – there is no mention of a requirement to involve family members in the process of
decision-making.
• Reflection – in our view, 14 days is too short a time frame in which to decide to be killed
• Coercion – we are concerned that vulnerable people will feel a coercive pressure to ‘do the

decent thing', whether to ease pressure on stretched healthcare resources, or to liberate
loved ones from the burden of ongoing care
• We are concerned about the psychological effect on doctors and nurses of killing someone who is not expected to die imminently and upon doctor/patient relationships.
Accessible, high-quality palliative care is, in our opinion, a better answer to the problem this Bill seeks to address.

Which of the following factors are most important to you when considering the issue of assisted dying? Please rank a maximum of three options.

ranking important factors - Impact on healthcare professionals and the doctor/patient relationship:

ranking important factors - Personal autonomy:

ranking important factors - Personal dignity:

ranking important factors - Reducing suffering:

ranking important factors - Risk of coercion of vulnerable people:
3

ranking important factors - Risk of devaluing lives of vulnerable groups:
1

ranking important factors - Sanctity of life:

ranking important factors - Risk of eligibility being broadened and safeguards reduced over time:
2

ranking important factors - Other – please provide further details in the text box (200 characters max):

If you selected Other, please provide your answer in the text box below:

Space for further comment on your answer:

We do not believe that the proposals fit the problem. The problem is not that palliative care is ineffective. It is that palliative care is not accessible across Scotland. The solution is not to eradicate the patient, but to invest in training and provision of more excellent palliative care services. Experience shows that where assisted dying is legalised, investment in palliative care services diminishes (Caldwell S. Palliative care and assisted dying – never the twain shall meet. Published in Conservative Woman, 19 November 2021.
https://www.conservativewoman.co.uk/palliative-care-and-assisted-dying-never-the-twain-shall-meet/).
We are concerned that legalising assisted dying would inevitably strengthen the perception that people with certain types of disease or disability have lives 'not worth living', that they would be 'better off dead', and that the costs of their care would be better directed towards healthcare provision for the more socially or economically 'productive' members of society. The quotient of compassion in the caring professions and respect for human life in society in general would inevitably ebb. We suggest that this would be out of step with the deepest intuitions of the people of Scotland.

Question 2 - Eligibility

Which of the following most closely matches your opinion on the terminal illness criterion for determining eligibility for assisted dying?

No-one should be eligible for assisted dying

If you selected Other, please provide your answer in the text box below:

Space for further comment on your answer:

In our view, it cannot be right to attempt to solve issues around end-of-life care by assisting patients to kill themselves. We believe, with H L Menken, that 'there's always an easy solution to every human problem – neat, plausible and wrong.'
As doctors and nurses engaged in caring for those at the end of their lives, our members are among those best placed to understand their needs.
The UK has been a world leader in the hospice movement, building on the foundations laid by pioneers like Cicely Saunders who famously said: 'You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die.'
The need for palliative care and end of life care is due to increase up to 42% in the next 20 years, as predicted by Marie Curie UK. Their 2016 report estimated that 1 in 4 people in Scotland who would benefit from palliative care when they are dying do not receive the care that they need. By legalising assisted suicide, the incentive to invest in palliative care will be reduced rather than increased.
Our appeal is that priority be given to training a new generation of palliative care specialists and to multiplying palliative care units and symptom control teams. There is enormous benefit to families where hospice-type care is locally available, and this also encourages 'ownership' by local

communities, which helps generate income through fund-raising and legacies.

Which of the following most closely matches your opinion on the minimum age at which people should be eligible for assisted dying?

No-one should be eligible for assisted dying.

If you selected Other, please provide your answer in the text box below:

Space for further comment on your answer:

As stated previously, CMF fundamentally opposes the legalisation of assisted dying. If it were to be introduced in Scotland, we suggest that the minimum age should be at least 18. The human brain continues to develop until our mid-20's, accordingly to studies in neurodevelopment. We suggest that 16-year-olds lack the capacity to make such irreversible decisions.

Question 3 - The Assisted Dying procedure and procedural safeguards

Which of the following most closely matches your opinion on the Assisted Dying procedure and the procedural safeguards set out in the Bill?

I do not agree with the procedure and procedural safeguards because I oppose assisted dying in principle

If you selected Other, please provide your answer in the text box below:

Space for further comment on your answer:

We strongly suggest that every person requesting assistance to die should automatically be assessed for mental health and capacity by a psychologist or other appropriate specialist, and not just if one of the two doctors assessing capacity is 'unsure.'
Existential angst is the most common reason given for requesting assisted dying. Conditions like anxiety and depression are amenable to treatment. Without qualified assessment of capacity, it is inevitable that some patients who could have been successfully treated will instead be helped to die.
We strongly urge that assessment of mental capacity, to include any evidence that the patient's request might be (knowingly or unwittingly) coerced, be made a requirement in every case, and that the assessment be made by a suitably qualified mental health specialist.

The safeguards proposed state that two registered medical practitioners should independently confirm the person is terminally ill. A 'registered medical practitioner' could equally refer to a recently qualified doctor or to a senior specialist with 30 years clinical experience. It is a fearful responsibility to give to someone lacking much in the way of clinical experience. Accurate prognosis is extremely difficult, even in the most experienced of hands. We suggest that the assessment of 'reasonable expectation of life' should be made by those best qualified to make it. We recommend that the Bill stipulate that at least one of the two doctors required to confirm the person is terminally ill should have had a minimum of ten years clinical experience in a field relevant to the condition involved.
Also, when looking for the second signature, it would be natural for the attending physician to seek out someone known to be supportive of assisted suicide. In this way, the system as drafted is seen to be open both to inexperience and unconscious bias.

Question 4 – Method of dying

Which of the following most closely matches your opinion on this aspect of the Bill?

It should remain unlawful to supply people with a substance for the purpose of ending their own life.

If you selected Other, please provide your answer in the text box below:

Space for further comment on your answer:

The proposals as they stand for providing the lethal draught:
• envisage a scenario where the attending RMP visits the home of the person seeking assistance to die.
It is quite likely that family members, and possibly even friends, will be gathered there, in a
state of high emotion. We suggest that a minimum of two healthcare professionals (HCPs) be required to attend, and not simply be an option at the discretion of the attending RMP
• the 'medicine' in question has to be self-administered, by mouth, in the presence of the attending RMP. In the event that the patient is unable to bring themselves to take the medicine and
requests the assistance of the attending RMP, no guidance is given.
• the barbiturate cocktail is unpleasant to take, may be regurgitated, or simply not be fully
effective. The common misconception is that the patient will fall asleep quickly and die
within minutes. The reality is often different. It may take much longer before the patient
dies, and sometimes they do not die following the prescribed dose. These are very
distressing scenarios, for the patient if he/she is still aware, and also for the family. No guidance for the attending doctor is given for these circumstances

Question 5 - Health professionals

Which of the following most closely matches your opinion on how the Bill may affect the medical profession? Tick all that apply.

Medical professionals should not be involved in assisted dying, as their duty is to preserve life, not end it., The Bill strikes an appropriate balance by requiring that there are medical practitioners involved, but also allowing those with a conscientious objection to opt out., Legalising assisted dying risks undermining the doctor-patient relationship

If you selected Other, please provide your answer in the text box below:

CMF appreciates the space given in the Bill for medical professionals to act in accordance with their conscientiously held beliefs.

Space for further comment on your answer:

We have concerns about the effect on the doctor/nurse-patient relationship of assisted dying
legislation. Trust is crucial to this relationship. The patient's confidence that the doctor will always
act in such a way as to 'do no harm' is foundational to the relationship. Giving doctors the power
deliberately to end the lives of their patients will inevitably redefine the nature of the relationship
and risks undermining that essential trust and confidence.
The long-term effect on doctors and nurses themselves could be equally damaging. They could
become hardened to causing death, and even begin to see their most vulnerable patients as
'disposable.' It is inevitable that some patients would decide not to ask for medical help, for fear that they be encouraged to consider assisted dying by doctors whom they feel they can no longer fully trust.

If assisted dying is legalised, we strongly urge that:
1. a statutory right of conscientious objection be included, that will apply equally to all healthcare
professionals, and cover both direct and indirect involvement, rather than relying on the guidance
published by professional regulatory bodies that may not even cohere;
2. an institutional right of conscientious objection, so that individual hospices etc can decide not to
provide assisted dying, without risking their funding. If this is not present in draft legislation, it would
place an intolerable strain on the ethos of many existing services.

Question 6 - Death certification

Which of the following most closely matches your opinion on recording the cause of death?

I do not support this approach because it is important that the cause of death information is recorded accurately

If you selected Other, please provide your answer in the text box below:

Space for further comment on your answer:

Keeping accurate records has always been an important duty for doctors and nurses. This enables best care for patients and also enables accurate research. Recording a false immediate cause of death would, for example, provide misleading statistics to researchers looking at trends in the causes of death in a population, with knock-on effects for the application of funds for research projects etc. It might also lead to inaccurate prognosis data for the diseases falsely recorded as the immediate cause of death.

We strongly believe that doctors should not be asked to lie about the immediate cause of a patient's deaths on a legal document. Supporters of legalising assisted suicide have argued strongly that there is no stigma attached to choosing to die by one's own hand. On the contrary, they argue, it is a valid and overdue expression of individual autonomy - the freedom to control how and when we die. It would therefore be spurious and disingenuous for them to insist that the immediate cause of death not be recorded as assisted suicide.

Question 7 – Reporting and review requirements

Which of the following most closely matches your opinion on the reporting and review requirements set out in the Bill?

The reporting and review requirements should be extended to increase transparency

If you selected Other, please provide your answer in the text box below:

Space for further comment on your answer:

If the Scottish Government is willing to legalise assisted dying, then it must track and make available for scrutiny the effects of that decision. Five years seems a long time to wait before reviewing the operation of the legislation. We consider that an initial 3 year period would be preferable.

Question 8 – Any other comments on the Bill

Do you have any other comments in relation to the Bill?

Please use this textbox to provide your answer:

We do not believe that the proposals fit the problem. The problem is not that palliative care is ineffective. It is that palliative care is not accessible across Scotland. The solution is not to eradicate the patient, but to invest in training and provision of more excellent palliative care services.
We are concerned that legalising assisted dying would inevitably strengthen the
perception that people with certain types of disease or disability have lives 'not worth living', that they would be 'better off dead', and that the costs of their care would be better directed towards healthcare provision for the more socially or economically 'productive' members of society. The quotient of compassion in the caring professions and respect for human life in society in general would inevitably ebb. We suggest that this would be out of step with the deepest intuitions of the people of Scotland