The Proposed End of Life Choices (Scotland) Bill

Response from the Scottish Council of Jewish Communities

Click here to read the consultation paper

The stated objective of the proposed End of Life Choices (Scotland) Bill is "*to clarify the laws in Scotland relating to the assistance given to end the life of a person requesting such help before death would occur naturally.*" The need for such clarification is, however, doubtful, since, as has been acknowledged in the consultation paper, Rhona Brankin, the then Deputy Minister for Health and Community Care has informed the Scottish Parliament that "*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.*"[1]

Halachah (Jewish Law) regards human life as being sacrosanct. Its value is absolute, not relative to a person's age or health, and it is certainly not something that can be ended at will. The commandment of *Pikuach Nefesh* (saving life) is central to Jewish belief - the Talmud states that "*one who saves a single life is regarded as if he had saved the whole world*" and other religious obligations must (not "may") be set aside in order to do so. Judaism is, therefore, unequivocally opposed to both euthanasia and suicide, and sets great store by the dedicated care given to patients in their final illness by members of the medical and nursing professions. However, whilst it is not permitted to shorten life neither is it permissible artificially to prolong the process of dying. Furthermore, a patient has no obligation to accept burdensome treatment even when it might appear to be his/her best option.

Jewish religious tradition gives clear guidance to those caring for terminally ill patients and for the patients themselves. Expressed simply, the principle is that it is forbidden to do anything that will hasten death. An eminent authority on Jewish law and ethics, Rabbi J.D. Bleich, has stated, in summarising the Jewish view on euthanasia: "*Any positive act designed to hasten the death of the patient is equated with murder in Jewish law, even if the death is hastened only by a matter of moments. No matter how laudable the intentions of the person performing an act of mercy-killing may be, his deed constitutes an act of homicide*." (Judaism and Healing, Ktav Books, 1981).

However, adequate pain relief supplied with the sole intention of relieving pain and distress is permitted by *Halachah* even if there is the possibility that the patient's life may be shortened in consequence. Since this is a complex area, consultation with doctors and a competent religious authority may be required to establish what is necessary for each individual patient.

Q1. What are your views on applicability requirements?

The consultation paper states that the "*proposed bill applies to capable adults*", but almost immediately goes on to state that although it "*will use the statutory definitions to determine if someone is capable*" it will "*invite comment on the age at which a patient might be judged capable of requesting assistance to die*". This is disingenuous, and can only serve to confuse the issue.

[1] Official Report, 11 November 2004
http://www.scottish.parliament.uk/business/officialReports/meetingsParliament/or-04/sor1111-02.htm#Col11892

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Q2. From what minimum age should a person be able to specify an end of life choice? Please give reasons for your answer.

The example given in this section of the consultation paper is not relevant to the stated objective of the proposed bill, which relates "*to the assistance given to end the life of a person requesting such help before death would occur naturally*". As the introduction points out, it is already *"legal for a person to exercise autonomy, and refuse treatment to preserve his or her life*", yet this section of the paper discusses precisely that situation, namely the case of a patient who has chosen not to undergo a heart transplant operation. This is misleading since the proposed Bill has no bearing on the situation, and, once again, this serves only to confuse the issue.

The inconsistent definitions of a child in existing Scottish legislation already cause some confusion, and we would strongly oppose any move to introduce a new definition. In this case, precedent would appear to have been set by the Human Tissue (Scotland) Act, which, whilst it permits a child from the age of 12 to authorise post-mortem organ donation and post-mortem examination, makes it an offence for any organ to be removed from a living child (defined as being under 16) for purposes of transplantation. This distinction was explained by the then Deputy Minister for Health and Community Care as being to "ensure that a child's long-term health interests are not compromised".[2] Any proposal to establish a right for a child under the age of 16 to choose an assisted death would therefore conflict with the intention of existing legislation, and we would strongly oppose any such move.

Section 2.3

In recent times, and in an increasing number of jurisdictions, patients are being advised to draw up advance directives, sometimes described as living wills. These documents permit patients to make clear their own wishes of how they wish to be treated in the event of a debilitating illness which may reduce their ability to consent to treatment. This appears to be recognised in the proposed Bill, since (2.3) "*The bill proposes that patients enjoying otherwise satisfactory health but with degenerative, irreversible conditions would make their wishes known to an attending physician*". However, since the consultation paper goes on to state that the attending physician should be "*qualified and registered as someone willing to help terminate life at the patient's request*", it would appear that there is an unfounded presumption in favour of the patient wishing to terminate his or her life.

The Jewish position on living wills is complex. It would not countenance living wills being used to facilitate euthanasia or suicide, whether active or passive. It would also be unhappy with a document being drawn up so far in advance of the final illness that the patient would be unaware of exactly what was being agreed to in advance. A valid Jewish living will should specify the religious authority to be consulted for advice on management of the incompetent patient in his or her final illness and may nominate a proxy, sometimes described as a health care proxy, who can be trusted to represent the view and opinions of the patient. This will usually be the next of kin or a close family member.

We are particularly concerned by the proposal that "*"Patients" who are not terminally ill, suffering from a degenerative condition, or unexpectedly incapacitated but who find their life to be intolerable may request assistance to end it*" which we presume is intended to refer to those suffering from depression or other mental illness. Its effect would be to extend the

[2] Official Report 25 October 2005 http://www.scottish.parliament.uk/business/committees/health/or-05/he05-2502.htm#Col2320

proposed provisions from those with irreversible degenerative conditions to include those for whom life is, perhaps temporarily, “intolerable”.

We have already referred to the statement in the consultation paper that the "*proposed Bill applies to capable adults*" (immediately contradicted by a suggestion that its application might be widened to include younger people). It further states that "*the proposed bill will use the statutory definitions to determine if someone is capable*" and quotes the Adults with Incapacity (Scotland) Act, that

"Incapable" means incapable of –

- *Acting; or*
- *Making decisions; or*
- *Communicating decisions; or*
- *Understanding decisions; or*
- *Retaining the memory of decision,*

by reason of mental disorder …

It would therefore appear that, despite the initial statement to the contrary, it is intended that the Bill may be applicable also to individuals with incapacity.

Q3. Do you feel a waiting period of 15 days is enough? If not, what would be a sufficient waiting period and why?

A "waiting period" presupposes consent to assist in the termination of life after that period has been completed, and we do not, therefore, believe that any length of time would be "sufficient".

Q4. Do you have a view on what constitutes a "valid and documented request"?

A requirement for documentation may be satisfied either by a signed and witnessed written statement, or by an audio or video recording of a verbal statement. Validity would depend not only on the individual making the request being fully informed, but also on verifiable evidence that the request did not result from real or perceived pressure on that individual. We do not believe that to be achievable.

Q5. Are there any other responsibilities you would add to the responsibilities of the attending physician?

Q6. Are there any other responsibilities you would add to the responsibilities of the consulting health professional?

The responsibilities of an attending physician and consulting health professional should relate only to the preservation of life and the alleviation of pain and distress, not to a deliberate intention to terminate life.

It is not, in our view, possible for a physician or other health professional to make a safe "*determination …that the "patient" … has made the request voluntarily*" (2.5(a)) since the patient may feel constrained to withhold information that would lead to a contrary determination. Moreover, being "voluntary" does not preclude a request from having been made as a result of real or perceived pressure. We are concerned that some people may feel pressured to request assistance to end their life because they believe that otherwise they will be a financial burden to their family or to the NHS, but that this may not always be apparent to the physician. The simple presence on the statute book of a law legalising a form of euthanasia would in itself introduce an additional psychological pressure on patients. No-

one should be forced into a position where they feel obliged to evaluate their life in such terms and it is our view that this Bill will tend to devalue life and relegate it to being a commodity.

Experience shows that doctors are not always able to anticipate the course of an illness to predict accurately when death might occur. However, information about a patient's prognosis (2.5(b)) provided in the context of a request from a patient for assistance to terminate his or her life, may exert considerable psychological pressure, causing the patient to feel a burden on family and friends if he or she does not request an assisted premature death. We believe it to be intrinsically wrong that anyone should be placed in this position.

We are also extremely concerned by the proposal that physicians and other health professionals should be required to "*Inform the "patient" of all feasible alternatives, including, but not limited to, hospice care and palliative care.*" (2.5(c)) We would presume that this is intended to include the "alternative" of the patient being assisted to terminate his or her life by one or more possible means, and we believe it to be entirely unacceptable that the deliberate ending of life should be regarded as one of a range of healthcare provisions.

Q7. If the proposed Bill did not specify a review committee, do you have any views on alternative arrangements or safeguards?

The establishment of a review committee to establish, after the event, that requests from an individual for assistance to terminate his or her life, were made "voluntarily", and that a physician did not act improperly in rendering such assistance is otiose. A physician deemed to have acted unlawfully might indeed face prosecution and imprisonment, but the fact would remain that an individual's life would have been prematurely "terminated" - i.e. that he or she would have been killed.

In the necessary absence of the patient, it is even less likely that a post-mortem review committee will be able to make a safe determination that he or she acted "voluntarily" than will the attending physician and consulting health professional, and we do not, therefore, agree with the proposal that such a committee should have the authority to "*exempt registered attending physicians from criminal liability*"

Terminology

The language employed in the consultation paper minimises what is being proposed. The people it purports to want to assist are not even those relying on life support systems about whom there may be debate as to whether they are actually “alive”. It is about people who are indisputably alive. The correct word for facilitating the transition from life to death is “killing”, not “assisted dying”, and any argument for legislating to permit it should be prepared to stand under that description. To do otherwise is to rely on a sophistical redefinition, not on the facts of the matter.

Summary and conclusion

The consultation document states that "*For some people the question is irrelevant because they believe God determines when life ends, and nothing that is proposed will compromise their belief. But our society embraces many people who do not share this belief, who believe in the autonomy of the individual in taking responsibility for, and exercising choice over how life is lived, including the end of life.*" This seems to imply that the choice lies between

religious belief and personal autonomy. This is a mistake. Dying denies the person all further choices, and consequently denies them all further freedom. (The same reasoning explains why people are not "free" to sell themselves into slavery.) It follows that the argument for suicide or assisted dying cannot legitimately be made on the basis of autonomy.

A decision to die can never be an unforced decision; in its nature, it relates to illness, concern about the impact that one is having on others, reflection on limited alternatives, and so on. Almost everyone who is in the situation where assisted dying might be considered, in a regime where suicide is permitted, falls under some pressure to comply. If the proposed Bill were to be enacted it would inevitably place a moral and emotional burden on those who are already suffering .

We are also concerned that the proposed lawful killing may become a cover for murder. The death of a burdensome relative may be welcome to some people, and even if safeguards were introduced to limit the scope for direct abuse, a considerable potential would still exists for indirect abuse.

Judaism believes that all people, including the dying, should be invested with dignity, and that the dying should be treated with the greatest respect. It disagrees absolutely with the suggestion that a dignified death is one that is "assisted" to take place before its natural time, and is entirely opposed to the putative ethic on which the proposed Bill is based. Indeed we would regard the basis of these proposals as entirely unethical, and, accordingly, cannot support the proposed Bill to any degree.

Note: The Scottish Council of Jewish Communities (SCoJeC) is the representative body of all the Jewish communities in Scotland comprising Glasgow, Edinburgh, Aberdeen, and Dundee as well as the more loosely linked groups of the Jewish Network of Argyll and the Highlands, and of students studying in Scottish Universities and Colleges. SCoJeC is Scottish Charity SC029438, and its aims are to advance public understanding about the Jewish religion, culture and community. It works with others to promote good relations and understanding among community groups and to promote equality, and represents the Jewish community in Scotland to government and other statutory and official bodies on matters affecting the Jewish community.

In preparing this response we have consulted widely among members of the Scottish Jewish community.