SUBMISSIONS BY THE CMA

TO THE SCOTTISH PARLIAMENT ASSISTED SUICIDE (SCOTLAND) BILL.

RESPONSE TO CONSULTATION

We, the Catholic Medical Association-UK (previously known as the Guild of Catholic Doctors), thank you very much for consulting us on this important matter, which certainly needs very wide-ranging discussion. We do not support the proposed Bill. In answer to your questions:

Q1. Do you support the general aim of the proposed Bill (as outlined above)? Please indicate "yes/no/undecided" and explain the reasons for your response.

We do not. We will give our main reasons, and then feel bound to state that we cannot accept the basic premise of the majority of the other questions.

a. The main reason is that, while we accept that the relief of individual suffering is at the heart of the proposal, the effect on the whole situation for Society at large will be deleterious. The individual will feel they are being encouraged to take this "way out" rather than being a "problem" and a "burden" to others. The whole "Carer/Patient" situation will be changed.

b. Legalized assisted suicide further devalues people in "old age" or "chronic illness" in the eyes of society, who believe they should be valued and loved.

c. There would be a deleterious effect upon Palliative and Hospice Care, if this legislation was passed and the developments seen in recent times would be slowed.

d. Good palliative care should mean that assisted suicide is not required.

e. The present situation allows for extraordinary cases, where the Courts treat people with compassion, while safe-guarding the rest of Society from pressures towards suicide.

f. We do not feel that the processes of pre-registration and first & second formal requests give sufficient attention to the possibility of properly managing depression, pain, poor social care/ support, and other causes of despair. We note the evidence base from Chochinov [1-3] that the desire to die is strongly related to the loss of hope, depression, poorly treated pain, fear of loss of ability and dignity and poor social support all of which are remediable.

g. We cannot share your welcome of the recent report by the Commission On Assisted Dying, chaired by Lord Falconer. It was one of the most one-sided Commissions we have ever seen set up [4-5]. With this in mind, we are again grateful for you consulting us on this matter.

Q2. What do you see as the main practical advantages of the legislation proposed? What (if any) would be the disadvantages?

We see no benefits from this legislation. With good palliative care people should not need to contemplate assisted suicide.

But there are large disadvantages; vulnerable elderly and frail people may feel a duty to die (note Baroness Warnock's statements on this) and legislation that agrees to the destruction of life will further devalue life and the dignity of the patients whom we serve.

Pressure on health professionals and a change in medical culture will have a negative impact upon the broader population of frail and dying people.

Q3. Do you consider that these suggested eligibility requirements are appropriate? If not, please explain which criterion or criteria you would like to see altered, in what ways, and why.

No answer- the premise of this question is not accepted

Q4. What is your general view on the merits of pre-registration (as described above)? Do you have any comments on what pre-registration should consist of, and on whether it should be valid for a set period of time?

No answer- the premise of this question is not accepted

Q5. Do you have any comment on the process proposed for the first and second formal requests (for example in terms of timings and safeguards)?

No answer,-the premise of this question is not accepted

Q6. Do you think a time-limit of 28 days (or some other period) is an appropriate safeguard against any deterioration of capacity?

No answer- the premise of this question is not accepted

Q7. Do you agree that the presence of a disinterested, trained facilitator should be required at the time the medication is taken? Do you have any comments on the system outlined for training and licensing facilitators?

No answer- the premise of this question is not accepted

Q8. What sort of documentation and evidence is likely to be required? In particular, how important is it that the process is filmed?

No answer- the premise of this question is not accepted

Q9. What is your assessment of the likely financial implications of the proposed Bill to your organization? Do you consider that any other financial implications could arise?

No answer-, the premise of this question is not accepted . Matters of life and death such as this may not be subordinated to financial and budgetary assessment.

Q10. Is the proposed Bill likely to have any substantial positive or negative implications for equality? If it is likely to have a substantial negative implication, how might this be minimized or avoided?

Introducing the ability to kill the frail and vulnerable brings profound jeopardy to vulnerable people. If these people may be killed, the imperative of providing good care is reduced. We already know that frail older people and people with learning disability access health care with greater difficulty than others. This bill will make it even harder for such people to access care.

We note that minority groups, including aborigines in Northern Australian Territories avoid health care when doctors are able to kill patients.

It should not be forgotten that the health care professions should also reflect the diversity of the population whom they serve. It is predictable that where professionals drawn from significant cultural, religious and ethical minorities feel compelled to participate in killing patients, they would be effectively excluded from working in these areas as a result of such legislation.

REFERENCES

[1] Chochinov HM, Wilson KG, Enns M, Mowchun N, Lander S, Levitt M, Clinch JJ. Desire for death in the terminally ill. Am J Psychiatry. 1995 Aug;152(8):1185-91.
www.ncbi.nlm.nih.gov/pubmed/7625468

The desire for death in terminally ill patients is closely associated with clinical depression--a potentially treatable condition-- and can also decrease over time. Informed debate about euthanasia should recognize the importance of psychiatric considerations, as well as the inherent transience of many patients' expressed desire to die.

[2] Chochinov HM, Wilson KG, Enns M, Lander S. Depression, hopelessness, and suicidal ideation in the terminally ill. Psychosomatics 1998;39:366–370.

Hopelessness was correlated more highly with suicidal ideation than was the level of depression. In multiple linear-regression analyses, hopelessness contributed uniquely to the prediction of suicidal ideation when the level of depression was controlled. For health care providers attending to the needs of dying patients, hopelessness appears to be an important clinical marker of suicidal ideation in this vulnerable patient population.

[3] Chochinov 2006 . Dying, Dignity, and New Horizons in Palliative End-of-Life Care. CA Cancer J Clin 2006;56:84–103. http://cuidadospaliativos.org/uploads/2010/04/Dying, dignity, and new horizons in palliative end-of-life care.pdf Fear of loss of ability and dignity also a significant factor in 53% of PAS

[4] McDonagh 2012. “Lord Falconer has the wrong ideas about assisted suicide”

http://www.spectator.co.uk/coffeehouse/7550648/lord-falconer-has-the-wrong-ideas-about-assisted-suicide.thtml

[5] P. Saunders 2012. “Lord Falconer and his sham Commission that could lead to 13,000 deaths a year”

http://www.dailymail.co.uk/debate/article-2082255/Lord-Falconer-sham-Commission-lead-13-000-deaths-year.html?ito=feeds-newsxml