Scottish Episcopal Church

General Synod of the Scottish Episcopal Church
Scottish Charity No SC015962

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Assisted Dying for Terminally Ill Adults (Scotland) Bill Consultation, question one response - *NEUTRAL*

Dear Mr McArthur,

The following submission is from the Church in Society Committee of the Scottish Episcopal Church (SEC). We have read and understood the Privacy Notice.

Our response argues for a wider and deeper understanding of what it means to die well, and for a well-supported palliative care route that involves skilled pastoral accompaniment of those dying, and of their carers and relatives, within the context of rich understanding of dying well.

Deepening the concept of dying well

In thinking through so sensitive a set of considerations as presented in the Assisted Dying for Terminally Ill Adults (Scotland) Bill, the Committee acknowledges that the Bill comes from a place of care and compassion. The Committee shares with the Bill a concern that people be supported to die well, and that relatives and carers are also supported; that accompaniment at the time of death includes accompaniment of relatives and carers. The Committee is wanting to widen and deepen our understanding of dying well beyond the focus on medical technicalities and people feeling 'denied control over their deaths' (Assisted Dying for Terminally Ill Adults (Scotland) Bill, 2.4).

Dying, in Christian understanding, is a placing of ourselves in God's hands, where we have always resided – whether we knew it or not. And in this sense, dying is a culmination and a transformation, in which human agency is not about the timing and technical procedures of death, but about how our 'inner nature' responds as our 'outer nature is wasting away' (2 Cor 4.16). There has been a medicalisation of the concept of the art of dying, as though that art began in the eighteenth century when laudanum was introduced to manage pain. But the art of dying is also a spiritual tradition, which, in Christian Europe, grew with the plague and culminated in the Seventeenth Century in the work and words of Jeremy Taylor: 'Dying is an art, best learned by us in health'. Discussion of assisted dying is likely to look different in a

context where the art of dying is remembered and practised as something that we can learn throughout our lives.

The prohibition of killing, shared by the SEC in common with all other Christian churches and derived from traditions shared in common with Judaism and Islam, embodies a wide-ranging and profound tradition of moral wisdom, teaching us to value life and compassion for life in all its needs. It has never encouraged the fantasy that the death of any individual can or should be kept at bay for ever. But it has gone hand in hand with a concern for the way we meet our death as a point at which truth before God, reconciliation of old wrongs and loving care for the dying person are all very important.

Of concern too when we look at other countries where assisted dying legislation is in place, for example in the Netherlands, that there has been significant 'mission creep'. There has been pressure to reduce the age limits and to include psychiatric illnesses.

Palliative care and pastoral care

Any moral tradition evolves practically in the face of new challenges, and provides new wisdom to meet new challenges. The development in the twentieth century of the practice of palliative care is a fine illustration of how this can happen: by giving priority to the relief of confusion and pain in a patient's last days it has encouraged a style of professional care for which "how" the approach of death is met is of greater importance than precisely "when".

Dying at peace with God and the world is a complex spiritual task, not simply a matter of absence of pain or clarity of mind. It involves forgiveness and reconciliation, trust and freedom from fear, the overcoming of anger, reflection on the life that is past and genuine gratitude for it. Accompanying the dying and their loved ones is a work of sensitive and informed pastoral care, which the churches have often been able to give, and the provision of which must be a priority for any constructive approach to care for death at the present time.

The question then arises whether the tradition could coherently evolve to allow for a measure of self-initiated death within a spiritually authentic and pastorally supportive context of this kind. The churches, seeking to articulate the tradition, have hitherto resisted this and for the most part still do resist it.

The reasons are broadly two:-

(i) There is a difficulty in pre-imagining the threshold of death itself, and what will appear important at that point, which makes it difficult to decide to terminate one's life in full knowledge of what one is doing. Christians have worried that there is bound to be something artificial and inauthentic about disposing of the end of one's days in this way before that end has come. Most of our decisions in life are about avoiding death, not encountering it. The decision, taken in advance, to terminate one's life rather than to allow it to end, looks like a strategy of avoidance rather than an honest coming-to-terms with our death and its implications. It seems to embody the fears that the living typically have of dying. It may also embody resentments at family or circumstances. Rather than expressing a will to die well, it seems to express a will to overcome death with management. Hence the Bill speaks to the fear people have of being denied control over their death. We also wish to acknowledge that anxiety about control over one's death has grown along with medical expertise in keeping us alive. Most people have multiple medical conditions towards the end of their lives, and life is preserved because each condition can be, and usually is, met with a procedure carried out by a specialised team. It would be valid to open up a wider conversation about technocratic approaches to medicine.

(ii) It is also difficult to believe in a purported exercise of autonomy and self-direction in this context. Dying is the moment of life at which autonomy has to be given up, and dying patients by definition are vulnerable. Other people are making decisions for them. The spectre of a decision to die being wrongly influenced always hangs over the situation. And one does not need to suppose that those who exercise the influence are badly motivated – though that can be the case, too. The very fact that they are well and active and struggling to "cope" with the situation creates the disequilibrium of initiative and autonomy.

These two concerns converge on a single point: the case for assisted dying in the current Bill hangs on the idea of a decision made by the dying person, in full understanding and freedom, to encounter the death that is approaching at this point in time, and not later. Is this decision, which everybody agrees is necessary if we are to distinguish assisted dying from suicide on the one hand, and from indirect murder on the other, merely a mathematical point with no dimensions? Is it the kind of decision of which human beings are capable within the circumstances of their humanity?

And so the urge for a wider lens through which to see humanity. By what or whom are we held throughout life, and as we contemplate our mortality and prepare for death? How do we understand the journey towards deeper life, which paradoxically takes place in the context of the journey towards death? This is one and the same journey as that towards our truer selves, in which, paradoxically, we discover that we are not the centre of our own lives.

The Church in Society Committee emphasises the need for pastoral care and accompaniment as people approach death, and as they reflect and make decisions about how to die. Can we support, societally, a growth in skilled accompaniment? The quality of spiritual accompaniment (often in the context of the excellent palliative care available in Scotland, as noted in the Bill), can change and deepen the nature of the conversation about dying well.

Where the conversation is focussed on control over when and how one dies, this is fear-based, and the fears are wholly understandable. The Committee is concerned that it would be cruel to deny people whose death is so imminent and inevitable, and who do not share our perspective, an avenue to end their lives safely. It also recognises the dynamic wherein some people, once permitted to take a route of assisted dying, become more open to not taking that route, and sometimes choose against it. The choice of using assisted dying or not does not come without the potential for increasing distress related to having that choice. Those who may worry about being a burden on family or wider society may have that concern exacerbated because they opt not to take the option or indeed feel there is greater pressure for them to take the option of assisted dying. There is emotional, psychological and spiritual wisdom to be explored here, and it is related to enabling people to address their fears fully, truthfully, and courageously. The addressing of fears is part of dying well, part of our inner growth as our 'outer nature' fades.

The Committee is grateful that the Bill points out that funding for palliative care often increases in contexts where assisted dying is permissible in law, and would wish that palliative care be developed and funded well outside of changes in law. We note that discussion of assisted dying occurs at a time when we still have very 'ableist' attitudes within society. In tandem inequalities still exist within health and social care with inconsistencies in people's ability to access care especially where we have particularly elderly populations in rural areas. Additionally cries for help should not be confused with the desire for assisted dying. Scotland should ensure that it is not driven down the cheaper option of assisted dying than providing good palliative care for all. Notwithstanding the very real and distressing experiences of dependence on others for care, loss of dignity, loneliness, and meaninglessness neither should it be discounted that there is a blessing to be found in the giving and receiving of compassionate care with access to a supportive social network, adequate income levels, appropriate housing, and good health and care services (especially mental health and psychogeriatric services). What are wise responses to the two paradoxes

of a) people choosing not to take assisted dying once granted permission to do so, and b) palliative care receiving a boost where assisted dying is legalised? Once fears and wishes are truly heard, our compass needle is perhaps no longer pinned in dread and can be freed to point where it needs.