SCoJeC
Scottish Council of Jewish Communities
Representing, connecting, and supporting Jewish people in Scotland

Proposed Assisted Dying for Terminally Ill Adults (Scotland) Bill

Response from the Scottish Council of Jewish Communities

The Scottish Council of Jewish Communities (SCoJeC) is the representative body of all the Jewish communities in Scotland. SCoJeC advances public understanding about the Jewish religion, culture and community, by providing information and assistance to educational, health, and welfare organisations, representing the Jewish community in Scotland to Government and other statutory and official bodies, and liaising with Ministers, MSPs, Churches, Trades Unions, and others on matters affecting the Jewish community. SCoJeC also provides a support network for the smaller communities and for individuals and families who live outwith any Jewish community or are not connected with any Jewish communities, and assists organisations within the Scottish Jewish community to comply with various regulatory requirements. SCoJeC also promotes dialogue and understanding between the Jewish community and other communities in Scotland, and works in partnership with other organisations and stakeholders to promote equality, good relations, and understanding among community groups.

In preparing this response we have consulted widely among members of the Scottish Jewish community, and this response reflects the views of all branches of Judaism that have communities in Scotland.

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1. Which of the following best expresses your view of the proposed Bill?

- ☐ Fully supportive
- ☐ Partially supportive
- ☒ Neutral
- ☐ Partially opposed
- ☐ Fully opposed
- ☐ Unsure

As we have been informed that our response will not be accepted unless we select a tickbox we have done so. Our view is not, however, “neutral” – indeed, neutrality entirely misrepresents the views of both the Orthodox and Liberal Jewish communities (see below). However, given the different, and strongly held views of the various branches of the Scottish Jewish community any other tickbox would be even more misleading.

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The Jewish Community in Scotland

The majority of the Jewish community in Scotland is affiliated to Orthodox Judaism, which has three synagogues in Glasgow, and one in each of Edinburgh and Aberdeen. In addition there is a Liberal Jewish community in Edinburgh, a Reform synagogue in Glasgow, and an unaffiliated Jewish community in Tayside and Fife. There are also several welfare organisations, including organisations providing care services to people with terminal or life-shortening illnesses or conditions.

Traditional Jewish religious law regards human life as sacrosanct. Its value is absolute, not relative to a person's age or health. The requirement to save 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.

Reform and Liberal Judaism differ in some respects from Orthodox or traditional Judaism. Reform and Liberal Judaism respect and consult Jewish law and tradition in making decisions but do not regard themselves as ultimately bound by it. In particular they respect the autonomy of individuals and the right of individual conscience in reaching decisions, especially on issues of deep personal concern such as end-of-life issues.

The views of all the Scottish Jewish communities are are reflected in this response.

Orthodox Judaism is unequivocally opposed to assisted dying, and sets great store by the dedicated care given to patients in their final illness by members of the medical and nursing professions. 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 or may hasten death, even, for example, so small an intervention as adjusting their pillow. The pre-eminent authority on Jewish medical ethics, Rabbi Dr 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 does not perceive the overriding obligation to preserve life to be in any way antithetical to "death with dignity". … the struggle for life is never an indignity.*"[1]

However, adequate pain relief supplied with the sole intention of relieving pain and distress is permitted by Jewish religious law, even if there is the possibility that the patient's life may be shortened in consequence. Since this is a complex area, patients and their families may request a consultation not only with doctors but also with a religious authority of their choice, in order to establish what is appropriate in any individual case.

Earlier this year Liberal Judaism formulated a new policy in support of legalising assisted dying, which states that, as people "*have had control over their life, they should also have control over their death in order to minimise the suffering of those dying in pain or indignity*"[2]. Liberal Judaism has become a founder member of the new Religious Alliance for Dignity in Dying, a collection of groups of various faiths,

[1] Judaism and Healing, Ktav Books, 1981

[2] Assisted Dying Q&A (Liberal Judaism, 2021)
http://www.eljc.org/newsletter/Dignity%20in%20Dying%20FAQs%20June%202021.pdf

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leaders and laypeople calling for a change in the law on assisted dying. Liberal Judaism emphasises, however, that assisted dying should only be "*one of several options for end-of-life care*". Many within Liberal Judaism oppose any change in the law because of ethical concerns about the inherent value of all life and the grave risk of coercion, while many others see it as the moral right of an individual to seek assistance in ending life which has become intolerable due to a terminal illness or terminal condition.

Reform Judaism is divided about assisted dying; it has no unequivocal position on assisted dying, and respects the differing views. However, there is a growing number of Reform Rabbis who believe that there are limits to the efficacy of palliative care, and who strongly assert that assisted dying should be permitted, providing that safeguards are in place to protect the vulnerable.

2. Do you think legislation is required, or are there are other ways in which the Bill's aims could be achieved more effectively? Please explain the reasons for your response.

The consultation paper states that "*Above all, [the proposed Bill] seeks to give peace of mind, comfort, and reassurance to those who need it most i.e. those who are suffering and dying*."

We doubt that anyone would argue with the aspiration expressed in this statement; certainly all branches of the Jewish community are strongly supportive of enabling those who are nearing the end of their lives to feel comforted, reassured, and at peace. However, as stated above, there are very significant differences of opinion as to how this should be achieved.

A senior doctor in the Scottish Jewish community has commented "*As a doctor I personally would not wish to support this bill, and instead consider improvements that are needed in social care, palliative care, and mental health services provision to ease suffering*."

Another senior doctor in the community expressed concerns about the potential impact of the Bill in other areas: "*I believe there is also a wider issue, and that is the effect of legislation such as this on our values as a society. Rather than encouraging and facilitating assisted dying I believe it is the duty of a society to strive to make all its members feel valued and respected. Additionally, at a time when we are witnessing an epidemic of psychological ill health in teenagers and young adults, I do not believe we should be enacting legislation that normalises the taking of one's own life*."

We dispute the claim in the consultation paper that "*Emerging from the pandemic, we have an opportunity to take the actions required to make sure that the end of life is more compassionate, fairer and more reflective of a dying person's choice. We have the ability to create a new standard for how we die*." We note that "standard" is ambiguous, and could imply an aspiration to make assisted dying not one of a range of options, but the norm, or default – which heightens concerns about the risk of coercion, and the right to conscientious objection. Furthermore, if we have learned anything at all from the pandemic, it is that, sadly, the reverse of this statement is true, and however much we all wish to ensure peace of mind, comfort, and freedom from suffering for dying patients and their families, we cannot always "make sure" that we can comply with a person's choice of how to die.

Legislation cannot change that, and it is wrong for such a claim to be made.

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3. **Which of the following best expresses your view of the proposed process for assisted dying as set out at section 3.1 (Step 1 - Declaration, Step 2 - Reflection period, Step 3 - Prescribing/delivering)?**

☐ Fully supportive

☐ Partially supportive

☒ Neutral

☐ Partially opposed

☐ Fully opposed

☐ Unsure

As we have been informed that our response will not be accepted unless we select a tickbox we have done so. Our view is not, however, "neutral" – indeed, neutrality entirely misrepresents the views of both the Orthodox and Liberal Jewish communities. However, given the different, and strongly held views of the various branches of the Scottish Jewish community any other tickbox would be even more misleading.

Please explain the reasons for your response, including if you think there should be any additional measures, or if any of the existing proposed measures should be removed. In particular, we are keen to hear views on Step 2 - Reflection period, and the length of time that is most appropriate.

We would have expected a requirement for the full team engaged in caring for and supporting an individual to be involved in the request procedure, including, for example, both hospital-based doctors and GPs, hospital, hospice, and community nurses, and the community psychiatric team. We are, therefore, concerned that these proposals only require the involvement of two medical practitioners, the attending doctor and an independent doctor, neither of whom is required to have known or provided care to the individual for any significant length of time.

We are also concerned that the proposed procedure cannot be relied on to ensure that an individual does not feel "coercion or duress" to request an assisted death. A rational decision to die would have to follow consideration, with family, friends, and carers, of the nature of the illness, concern about the impact that one is having on others, reflection on the available alternatives, and even on the perceived attitude of the health care team. If any of these, or either of the two doctors countersigning the request, believe that, were they in the situation of the requesting person, they would not wish to go on living, this view will undoubtedly be communicated, by tone and body language, if not in words, and will be an additional pressure on the person to proceed. In particular, the position of trust occupied by the two countersigning doctors in relation to a person requesting an assisted death, would itself lend weight to their view, whether explicitly stated or only implied.

Moreover, having reached a "clear, settled, and voluntary intention" 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 their need for care will otherwise be a financial and/or emotional burden to their family or to the NHS, but this may not always be apparent to those assessing the request. The mere presence on the statute book of a law legalising assisted dying would in itself introduce an additional psychological pressure on patients.

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4. **Which of the following best expresses your views of the safeguards proposed in section 1.1 of the consultation document? Please explain the reasons for your response.**

☐ Fully supportive

☐ Partially supportive

☐ Neutral

☒ Partially opposed

☐ Fully opposed

☐ Unsure

As we have been informed that our response will not be accepted unless we select a tickbox we have done so. Our view is not, however, "opposed", partially or otherwise. Neither, as we have stated below, are we "supportive", "neutral", or "unsure". However, any other of the tickbox responses would be even more misleading.

We are "concerned about" rather than either "supportive of" or "opposed to" the safeguards proposed in the consultation paper. While we fully accept that Liam McArthur's intention is to ensure "*robust safeguards"* alongside any introduction of assisted dying, *"to ensure that vulnerable people are not adversely affected*", we recognise that it is extremely difficult to implement effective safeguards for a measure such as this

The difficulty of getting safeguards right is exemplified, for example, by the need for repeated amendment of the Protection of Vulnerable Groups (Scotland) Act and many of the issues raised during parliamentary consideration of the Hate Crime and Public Order (Scotland) Act. However, neither of these Acts nor other similarly problematic legislation is irreversible for the people concerned, but assisted dying cannot be undone or remedied if safeguards are later found to have been insufficient.

The death of a burdensome relative may be welcome to some people, and we are therefore concerned at the possibility of misuse of assisted dying as a cover for murder, particularly as the proposal not to include information on the death certificate risks subverting existing legislation that was introduced to prevent another Shipman scandal (see our response to the next question). Although the proposed safeguards may limit the scope for direct abuse, a considerable potential still exists for indirect abuse, not to mention well-intentioned but dangerous legal uncertainly.

Furthermore, experience in other countries has shown significant erosion of the safeguards introduced with their original legislation. In Holland, for example, there has been 'creep' whereby legislation originally introduced for mentally competent adults with illnesses that would prove terminal in the relatively short term, has been stretched to apply to people with dementia, psychiatric illnesses, old age – and, by contrast and with parental decision, for children from as young as one – 'completed lives', and people who are care-dependent on a terminally ill partner[3]. The result of this has been that 4.5% (6,938 in 2020) of all deaths in the Netherlands are by euthanasia[2], and there

[3] Prof Dr Theo Boer, Professor of Healthcare Ethics, University of Groningen. From 2005 to 2014 Prof Boer held a regulatory role in relation to euthanasia in the Netherlands, when he served on one of the five Regional Review Committees on Euthanasia. Presentation to Holyrood webinar "Assisted suicide & euthanasia", November 2021 https://www.youtube.com/watch?v=sEH2qH9R1G4

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have been high profile controversial cases such as the doctor acquitted on grounds that "all requirements of the euthanasia legislation" had been met when he acted on a dementia patient's advance directive to the extent of asking her family to hold her down when she struggled against administration of the lethal drug[4].

In Canada, the reflection period between a written request for an assisted death and delivery of the lethal drugs has now been removed so that, in some cases assisted death takes place on the same day that the request is first made, and the original application for terminally ill patients has been expanded to include chronic illnesses such as diabetes and osteoarthritis, and, from March 2023, will also be permitted on grounds of mental illness without any comorbidity[5].

5. Which of the following best expresses your view of a body being responsible for reporting and collecting data? Please explain the reasons for your response, including whether you think this should be a new or existing body (and if so, which body) and what data you think should be collected.

☒ Fully supportive

☐ Partially supportive

☐ Neutral

☐ Partially opposed

☐ Fully opposed

☐ Unsure

If assisted dying were to be introduced in Scotland, we would support the creation or nomination of a responsible professional body to collect and monitor full data concerning assisted dying, and produce regular public reports on the data collected.

We are, however, concerned by the proposal in the consultation paper that "*in the interests of privacy … the primary cause of death would be noted [on death certificates] as the underlying illness from which the person died*". If assisted dying were to be legalised, there is no valid reason why its use should be regarded as any more private than the underlying illness. Moreover, permitting – indeed requiring – this information to be withheld would, as mentioned above, seriously undermine legislation introduced to prevent a repeat of the appalling abuse perpetrated by Harold Shipman. In order to ascertain that assisted dying were to be used only according to the law, and not as quasi-legal cover for a serial killer, Medical Reviewers must be able to investigate and assess the accuracy of the information provided on death certificates. In addition, omitting this information from the death certificate could severely limit the data available to the monitoring organisation, and result in a false understanding of how, and how widely, assisted dying was being used.

As stated in the consultation paper, "*Death certificates are public documents*", and it is important for regulatory oversight, research, and indeed the historical record, that they

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[4] Dutch euthanasia case: Doctor acted in interest of patient, court rules (BBC, September 2019) https://www.bbc.com/news/world-europe-49660525

[5] Dr Leonie Herx, Past President of the Canadian Society of Palliative Care Physicians, head of palliative care at Queen's University, Ontario. Presentation to Holyrood webinar "Assisted suicide & euthanasia", November 2021 https://www.youtube.com/watch?v=OWD5prkU7vs

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provide true and accurate information. In the absence of such information, it would not, for example, be possible to identify trends and geographical variations as has recently been published about the Netherlands.[6]

6. Please provide comment on how a conscientious objection (or other avenue to ensure voluntary participation by healthcare professionals) might best be facilitated.

We strongly agree with the view expressed in the consultation paper that no healthcare professional with a conscientious objection should be required to participate in the provision of assisted dying, but, in light of case law relating to abortion[7], we have concerns about the practicality of implementing this.

The consultation paper proposes that a patient requesting an assisted death must first discuss their request with "the attending doctor" and a second "independent doctor". We have already noted our concern at the limited involvement of healthcare professionals in the request process. If the "attending doctor", who presumably has some knowledge of the patient and his or her condition, has a conscientious objection to assisted dying, he or she will, of necessity, be replaced by a doctor without such knowledge, thus reducing still further the reliability of the doctors' conclusions about the safety of the patient's request.

General Medical Council guidance[8] states that doctors may "*practise medicine in accordance with their beliefs, provided that they act in accordance with relevant legislation and do not treat patients unfairly, do not deny patients access to appropriate medical treatment or services, and do not cause patients distress. If any of these circumstances is likely to arise, we expect doctors to provide effective patient care, advice or support in line with "Good medical practice", whatever their personal beliefs.*" If, therefore, a change of attending doctor would cause the patient distress, according to the guidance, the doctor would be required to participate in the assisted dying process "whatever their personal beliefs" – that is, even if such participation is contrary to their personal conscience.

Furthermore, in remote rural and island communities, there may not be another available doctor to replace a colleague with a conscientious objection. In this case too, the doctor's right not to participate in assisted dying would be negated by his or her obligation not to deny access to a legal medical service "whatever their personal beliefs".

While we welcome the policy intent, we are, therefore, concerned that it would not be possible to ensure effective implementation of the policy intent "*that no person will be obliged to participate in the assisted dying process*."

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[6] For example: *Euthanasia in the Netherlands: a claims data cross-sectional study of geographical variation* (A Stef Groenewoud, Femke Atsma, Mina Arvin, Gert P Westert, Theo A Boer, BMJ Supportive & Palliative Care, 2020) https://www.researchgate.net/publication/348494675_Euthanasia_in_the_Netherlands_a_claims_data_cross-sectional_study_of_geographical_variation/download

[7] Catholic midwives lose abortion case at UK Supreme Court (BBC, December 2014) https://www.bbc.com/news/uk-scotland-glasgow-west-30514054

[8] Personal Beliefs and Medical Practice https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice/personal-beliefs-and-medical-practice

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7. **Taking into account all those likely to be affected (including public sector bodies, businesses and individuals etc), is the proposed Bill likely to lead to:**

☐ a significant increase in costs

☐ some increase in costs

☐ no overall change in costs

☐ some reduction in costs

☐ a significant reduction in costs

☒ don't know

Please indicate where you would expect the impact identified to fall (including public sector bodies, businesses and individuals etc). You may also wish to suggest ways in which the aims of the Bill could be delivered more costeffectively.

It is obviously impossible to form an opinion on the overall financial consequences for all those likely to be affected, but in any event we do not believe that the total net cost or saving is relevant to what is essentially an ethical question. The question itself implies that costs to an individual can be outweighed by savings for another individual or for the state, so we would reiterate that no person should be brought to feel that they must request an assisted death either because of their own financial position, or because an extended illness might cause financial difficulties for their family.

8. **What overall impact is the proposed Bill likely to have on equality, taking account of the following protected characteristics (under the Equality Act 2010): age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation? Please explain the reasons for your response. Where any negative impacts are identified, you may also wish to suggest ways in which these could be minimised or avoided.**

☐ Positive

☐ Slightly positive

☐ Neutral

☒ Slightly negative

☐ Negative

☐ Unsure

Scotland is not a special case, and given that the availability of assisted dying in other jurisdictions has expanded from only the terminally ill to include chronic conditions as well as mental illness, we have to accept that the same may be likely to happen here. Speaking in the House of Lords Second Reading Debate on the UK Assisted Dying Bill in October 2021, Baroness Grey-Thompson commented that, in many ways, as a paralympian athlete and parliamentarian she is very privileged, but that as a disabled person, she suffers considerable discrimination. She continued, "*Many people have also said to me, "If my life was like yours, I would kill myself." I have a huge amount of privilege in my life, but if people think this, it becomes very easy for them to conflate disability and a six-month diagnosis, and decide that we have no right to live*." and expressed concerns that "*We do not live in an equal society. This Chamber has spent*

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considerable time looking at coercive control. Why do we accept that in domestic abuse legislation but assume that in this legislation it would never happen?"[9]

We are very concerned that the consultation paper appears to validate assisted dying on grounds other than a patient's personal pain, feelings of indignity, etc. Under "Gender" in Section 4.1, it states "*Research has shown that the lack of choice at the end of life disproportionately and detrimentally affects women who continue to be the primary care givers at the end of life*." and references *Dying in Scotland: A Feminist Issue*[10]. This document states, "*The majority of carers are women and when this is coupled with the desire to care for people in their own homes and the blanket ban on assisted dying, we can infer that many women witness the distressing end-of-life symptoms that some people suffer at the end of life and bad deaths at a disproportionate rate to men. Witnessing traumatic deaths can increase the likelihood of complex grief and post-traumatic stress disorder*." It also comments on difficulties faced by nursing staff in such situations, and further states, "*It's therefore not only unpaid carers who witness the effects of a lack of choice at the end of life in Scotland, but also nurses – the majority of whom are women*."

We are shocked that this document should have been referenced in support of the proposed Bill. Its implied contention, quoted above, that assisted dying should be made available in order to relieve nurses and carers is appalling. Furthermore, the implication that men are better able than women to cope with stress and trauma is not only contradicted by, for example, the large body of research about male combat veterans suffering from PTSD, but also risks driving male sufferers to hide their illness, and perhaps even resort to suicide if they perceive themselves as having 'failed' to remain stoical in the face of tragedy.

A request for an assisted death should not be based on feelings of guilt that continuing to live will impact negatively on carers or healthcare professionals. Such 'guilt-tripping' is a form of coercive control, and the implication that it is acceptable also opens the door to other forms of coercive control over vulnerable terminally ill patients.

9. In terms of assessing the proposed Bill's potential impact on sustainable development, you may wish to consider how it relates to the following principles:

- **living within environmental limits**
- **ensuring a strong, healthy and just society**
- **achieving a sustainable economy**
- **promoting effective, participative systems of governance**
- **ensuring policy is developed on the basis of strong scientific evidence.**

With these principles in mind, do you consider that the Bill can be delivered sustainably? Please explain the reasons for your response.

☐ Yes

☐ No

☒ Unsure

[9] Assisted Dying Bill, Second Reading, House of Lords (October 2021) https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL)#contribution-ADCCABCD-B4E6-414B-8EBE-175C9C21735E

[10] Dying in Scotland: A Feminist Issue https://features.dignityindying.org.uk/dying-in-scotland/

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As we have been informed that our response will not be accepted unless we select a tickbox we have done so. We are not “unsure”. However, given strongly held views of the various branches of the Scottish Jewish community any other tickbox would be even more misleading.

We do not believe that these issues are relevant. Were this legislation to be passed, patients should not feel required to make decisions about potentially ending their lives on the basis of environmental limits, achieving a sustainable economy, relieving carers, or any other overarching policy objective.

10. Do you have any other additional comments or suggestions on the proposed Bill (which have not already been covered in any of your responses to earlier questions)?

All branches of Judaism believe that all people, including the dying, should be invested with dignity, that the dying should be treated with the greatest respect, and that every effort should be made to encourage patients to find meaning in their lives, however circumscribed by illness and incapacity.

Orthodox Judaism disagrees entirely with the suggestion that a death that is "assisted" to take place before its natural time can be described as “dignified”, and in any event is absolutely opposed to the ethic on which the proposed Bill is based.

Liberal Judaism takes the view that it is the right of a terminally ill, mentally competent adult to have the choice of an assisted death if they are facing unbearable suffering.

Reform Judaism has not adopted a formal position about assisted dying, and respects the differing views of its membership.

There is clear evidence from the Netherlands, Canada, and elsewhere that where assisted dying is permitted, very many people in a situation where assisted dying might be considered, fall under some pressure to comply, and we are concerned that the enactment of these proposals may place a moral and emotional burden on those who are already suffering, and to cause health professionals whose conscientious objections cannot be accommodated to leave their profession.

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