End of Life Assistance (Scotland) Bill

Dr James D M Douglas

I write to register my profound objection to the above Bill, which has been proposed by the Scottish Parliament.

End-of-life issues have been extensively discussed in the media, House of Lords and Houses of Parliament recently using a variety of terms including Assisted Suicide and Voluntary Euthanasia. This matter has previously been raised in the Scottish Parliament by Jeremy Purvis and I enclose a copy of my previous letter on this topic, which raises objection in principle and the detail of terminology and implementation.

The recent media and public debates on Assisted Suicide in the United Kingdom have been based around high profile cases and the assistance of relatives in attending the Dignitas Clinic in Switzerland. The arguments in favour of Assisted Suicide have been based upon self autonomy and an individuals desire to be in control of their own destiny. However, the practical application of such a measure, no matter how convincing individual case experiences reported in the media or courts appear, would be disastrous for the elderly and vulnerable in society and for future relationships between doctors and patients.

Once the principle for Assisted Suicide and Voluntary Euthanasia has been established, it will be impossible and indeed immoral to make any further judgements on when that action should take place. Thus, an apparently symptom-less individual with a genetic pre-disposition to a disease, such as Huntingdon’s Disease, may request Voluntary Euthanasia while they have capacity and well before the appearance of symptoms. Any system produced with good intent and with full regulation will inevitably become the subject of casual disregard, like the application of the abortion laws, with huge unintended consequences upon society and human relationships.

With regard to the consultation questions, my responses are as follows:

Do you agree a person should be able to request End of Life Assistance from a Registered General Medical Practitioner?

No

Are you satisfied with the requirements for age and connection with Scotland as set out in the Bill?

The requirements to have been resident for 18 months avoid the prospect of “suicide tourism” and the requirements for Practitioners to have no family or financial interest in the process are sensible.

Lowering the age of request to 16 would be illogical, given that the age for drinking alcohol is 18.
Are you satisfied with the 2 categories of people who would qualify to be assisted under the terms of the Bill?

The definition of a terminal illness is notoriously difficult in clinical practice. The disease trajectories of malignant and non-malignant conditions are varied and prognosis is often incorrect. The recent case of Abdul Al Megrahi, who was released on compassionate grounds with less than 6 months life expectancy, following high profile assessments and decision-making, demonstrate the practical difficulties of prognosis.

The category of progressive, irreversible conditions, were life has become intolerable, would effectively mean that somebody with a positive blood test for Huntington’s Chorea, who was mentally distressed by that diagnosis, many years before the onset of symptoms, could request Assisted Suicide. If this principle is established, clearly nobody has the right to say no and refuse such a request at any stage in the disease trajectory. A time-limit of 6 months is purely arbitrary.

**The Bill outlines a several stage consent and verification process that would be required to be followed for the eligible person to receive End of Life Assistance, are you satisfied with this process?**

The requirement for a two-stage process with 30 days in between would be a practical safe-guard if the Bill was implemented.

**Do you consider the level and nature of the safe-guards, as set out in the Bill, to be appropriate?**

The safe-guards, as described, are satisfactory but the main impact would be upon the elderly, vulnerable and disabled in society, who would feel an unspoken obligation from carers and those around them to seek an end of life.

**Do you have any other considerations on the Bill not included in answers to the above questions?**

The process of deliberate self-harm is not considered by the Bill. If a person voluntarily and of their own free will, takes an overdose of tablets on two separate occasions, separated by 30 days within the same year, should the medical staff in A&E withhold resuscitation attempts on the 3rd occasion? Why should the medical profession contravene the expressed and deliberate self intention of an individual to prevent suicide in these circumstances?

In conclusion, I would ask all MSPs to reject this unsound change to Scottish Law & society.

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General Practitioner with 30 years clinical experience of palliative care
8 April 2010
09 March 2005

Mr Jeremy Purvis MSP
The Scottish Parliament
Edinburgh EH99 1SP

Dear Mr Purvis

RE: “DYING WITH DIGNITY” - PROPOSED RIGHT TO DIE FOR THE TERMINALLY ILL BILL

I write in response to the Consultation document to the above bill as a medical graduate of 30 years with 25 years experience as a General Practitioner, including palliative care. I have never appeared before the GMC or any other disciplinary authority.

I believe the above bill to legalise Assisted Suicide in Scotland would be wrong for patients, society and the medical profession for the following reasons:

Points of Medical Principle

1. The fundamental law of medicine “first do no harm” remains our most important principle in prescribing, treatments and operations. The proposal threatens our most fundamental principle.

2. Trust in the doctor/patient relationship is built upon the understanding that doctors will never intentionally harm or kill their patients, despite their vulnerability.

3. Judgements on quality of life are personal and inevitably flawed from different perspectives of patient and doctor.

Lessons From History

1. The German Psychiatrists who faced rationing decisions after the First World War in mental asylums came up with the concept of a “life unworthy of a life”. They reasoned that some people with severe mental deficiency were a drain on resources and practiced involuntary euthanasia as a means of rationing. This principle was adopted and corrupted by the Third Reich as a means to implement eugenics and the final solution. Thus, the German Psychiatrists, allowed themselves to kill patients, with probable good intent, ended up providing the incremental technology and moral structure for politically-motivated genocide.

2. Dame Janet’s fifth report on Dr Harold Shipman suggests that his first child victim in Pontefract Infirmary was a “mercy killing” with misinterpreted communication by Shipman and the mother of the child with Cerebral Palsy who had said “don’t let her suffer Doctor”. We can only speculate but at that stage Shipman might have thought that he
was doing the right thing in the context of the paternalistic-medical relationship of the 1970's. Having crossed the Rubicon to kill his first patient, a pattern perhaps became established in an abnormal personality.

3. Abortion law was framed in the 1960's at the behest of Gynaecologists who were horrified by the results of “back-street abortions” in a small number of women. Well-intentioned desire to at least do the inevitable abortion procedure cleanly and safely has resulted in a social revolution over the following 40 years, which could not have been predicted. A procedure which was brought in with great principle and thought has now become routine clinical practice. Today, the forms are signed without a thought to effectively produce abortion on demand. Thus, a medical procedure to help prevent suffering a small group is quickly adopted as a right in everyone, with minimal control and a proportion of unexpected psychological harm. Doctors who are conscientious objectors to abortion are effectively prevented from careers in Gynaecology. The similar clause in Jeremy Purvis’ bill could blight General Practice as a career option for medical graduates who do not wish to provide the means to kill their patients.

**Practicalities of assisted suicide in clinical practice**

1. Suicide continues to be a problem in the Scottish NHS. What would be the moral reasoning behind encouraging suicide in physical distress but trying to prevent it in mental distress?

2. Suicide always blights the lives of those who are left behind. The widespread acceptance of suicide as an accepted principle in society could potentially cause harm in the relatives or professionals who administer the drugs in patients without physical capacity.

3. A practical requirement to require the physical capacity to swallow a death pill by the patient’s own hand would increase pressure for early assisted suicide while patients were still judged to have mental and physical capacity to commit the act.

4. The Adults with Incapacity Act has demonstrated that the judgements on capacity are exceedingly difficult in practical determination in real patients.

5. Prognosis has always been notoriously difficult to predict. Patients with proven metastatic breast cancer, for instance, can live for 5 years and young men with metastatic testicular cancer can now be cured. Prognosis can change with new treatments.

6. In dread neurological disease, such as Huntingdon’s Chorea, it may take more than 10 years from the onset of symptoms until death. The knowledge of a positive, predictive test for Huntingdon’s Chorea will be many years in advance of symptoms development. If this legislation is passed, apparently normal healthy people with minimal symptoms of
Huntingdon’s Chorea will request Assisted Suicide well before they develop major health problems. How can an arbitrary prognosis of 6 months life expectancy be judged in many progressive neurological conditions?

7. If the principle of allowing Assisted Suicide has been established in a small number of patients with aggressive neurological conditions, on the basis of 2 verbal requests, separated by time, it will be difficult to justify treatment interventions in people who have taken deliberate drug overdoses on more than 2 separate occasions. This would be particularly so if the overdose patient had no definable mental illness once they had recovered from the first 2 overdoses. Why should an arbitrary time limit of 6 months and a serious illness make any difference in principle once this Rubicon has been crossed?

8. In order to establish Assisted Suicide as an accessible option in routine clinical practice, the mechanisms to operate it will have to be low-level, routine and based upon the trust of doctors. This is potentially a recipe for abuse and it will be almost impossible to catch future medical murderers.

In conclusion, I believe this genuine attempt to help the suffering of a small number of people with dread neurological disease will have untold consequences upon the doctor/patient relationship and society in the future.

It has been argued that the concerns about doctors who murdered during the Third Reich or on their own account, as Shipman, are irrelevant to this discussion where a patient is voluntarily requesting euthanasia. However, all such patients are subject to pressure from families and society. This is a particularly important point with the demographic changes in modern society and our increasing knowledge from genetic testing.

Many bad laws are constructed on the basis of rare or unusual events. I believe that changing the fundamental rules of the doctor/patient relationship for an intended few hundred people per year with dread neurological disease, will alter forever the doctor/patient relationship in the rest of society, once the position of assisting medical killing has become sanctioned in law.

I believe the solution to the difficult end of life problems with modern medicine arise from the application of inappropriate medical technology and an inability to stand back and let nature take its course. As doctors, we should be seeking society’s permission to not always intervene towards the end of life. The current dividing lines for life and death in the bedrooms of patients with terminal cancer are visible and understandable to patients, their families and doctors. I believe we meddle with these principles at great peril as we cannot predict the consequences of allowing doctors to kill their patients.

Yours sincerely
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