End of Life Assistance (Scotland) Bill

Dr David Gray

As a Consultant in Palliative Medicine I clearly have an interest in the End of Life Assistance Scotland Bill. However, I have a greater interest as a citizen of this country, who would wish that any changes to the laws by which we are governed are clearly thought through and bring added benefit to the population as a whole. It is important at this point to state that I very much value the hard work that Ms MacDonald has put into producing this Bill and that we share a common desire to ensure that people in the last part of their lives achieve a peaceful and dignified death, although we differ in our views as to how this may be achieved. I previously have not commented in relation to the End of Life Assistance Bill and have maintained a neutral position with an open mind awaiting the publication of the Bill to determine if I felt it could meet its desired aims. In its current format I could not support it due to a number of reasons which I will explore in detail below. I doubt very much that the questions I have in relation to this Bill are only held by myself. I will also suggest some proposals which may be worthy of debate when considering this subject.

From my reading of the Bill and the accompanying notes, I fully understand the desire to expect “certainty, cogency and clarity” in relation to assisted suicide. I understand this Bill is an attempt to provide this clarity and produce a framework with safeguards to protect the most vulnerable. These issues I believe are mainly legal rather than medical in nature. Suicide is not a crime in Scotland but assisting a suicide is and if there is a societal and parliamentary wish to change this legislation then this may occur. What I disagree with is the production of a framework with the central involvement of the medical profession to provide the safeguards. The reason for this disagreement and some other comments in relation to the Bill are discussed below.

I firmly believe that any change in the law which would require doctors to consider assisted suicide for their patients would irrevocably change the current doctor / patient relationship. We currently have clear guidance from the GMC in relation to withholding treatment and also the administration of treatment which may have the side effect of shortening life. In both these cases the ending of life is not the prime intent and though the outcome may be the same as assisted suicide, there is a lack of intent. It is questions surrounding this intent that I believe will result in many doctors not wishing to be involved in assisted suicide. At a time when patients will most benefit from continuing to be cared by doctors who they know and trust this relationship could be altered if their doctor is unable to carry out their wishes and has to refer to another colleague. If many doctors raise conscientious objection to assisted suicide, a patient may have to attend many different consultations trying to find a physician who will accept their case. I do not think this would ultimately improve the care and dignity of patients.
In relation to the construction of the process by which the patient requests assisted suicide, I do not agree with the assumption that this workload will be easily assimilated into current general practitioner workload. To properly work through the process of dealing with a patient with a life limiting illness who requests assisted suicide can take many hours. I know this from personal experience. At the present time we do not have assisted suicide in Scotland but some patients do wish to consider going to Switzerland. I have been involved in such cases and have taken a neutral position so best to maintain my relationship with the patient but it has taken many hours to explore all the issues. In most cases patients also wish family members to be involved in discussion which means arranging various meeting times to suit these different members. General practice has huge pressures placed upon it at present and though I agree with the accompanying notes of the Bill that the ultimate numbers of completed assisted suicides potentially would be less than the number of enquiries, I would foresee that there would be a large increase in workload within general practice, especially if the appropriate discussion surrounding this subject were to take place. I therefore disagree with point 108 in the explanatory notes. I think it may be difficult to receive the appropriate time required by both general practitioner and the psychiatrist. In relation to the discussion which these medical colleagues have with their patients, I also would wish them to be fully appraised of palliative care services so that patients are having the appropriate choice. Again, these discussions may well take many hours.

In relation to prognostication and the fact that the patient is required to be in the last six months of their life, it is important to point out that this can be a fairly difficult prediction to make with certainty in many cases. There will always have to be judgement calls in relation to prognostication but I think it is something that has to be considered very carefully in relation to assisted suicide. This has bearing on other aspects of the Bill when considering possible conditions in which patients may wish to receive assisted suicide. In the accompanying notes it is suggested that the Bill may actually lead to the prolonging of life as patients may not need to travel to a foreign country while they are physically able. I still foresee that life may be shortened prematurely in the manner by which this Bill has been constructed. This is due to the fact that it relies on competency. If the patient has an illness which inevitably will result in a lack of competency, then they most likely will have to take their life before this happens. Therefore a situation where competency is fluctuating but times in between where quality of life is good life may be cut short as patients who wish assisted suicide will have to weigh up the balance of whether to end their life sooner when they have competency or risk losing the option of assisted suicide when competency is lost or fluctuating.

The explanatory notes to the Bill also suggest it will improve equity. I think this Bill would provide less equity to a number of our society. In any framework which is constructed to protect the most vulnerable, there will be points at which certain people will no longer be eligible. I however find it difficult to weigh up why one group should be more eligible than the other if they all feel their suffering is intolerable. An example of this would be a patient with severe mental health illness who feels their quality of life if intolerable, however due
to fluctuating competency they would not be eligible. When viewed from this angle, this Bill seems to provide the ability to create inequity. However as stated above, that may be one of the trade offs in terms of allowing a certain proportion of society to receive assisted suicide.

Despite the above concerns, I fully acknowledge that this issue will not be resolved without further discussion and I recognise that personal autonomy is fundamental to the human experience. I think if there is a wish to provide clarity in relation to the law, then this should be done so without necessarily producing a framework with the central involvement of the medical profession. If society deems it appropriate for assisted suicide to made legal, then this could encompassed by a central body, separate from the medical profession. This would allow the training of individuals in appropriate counselling skills with appropriate time available to support people wishing to enquire about assisted suicide. Training could also be given to ensure quality assurance in the act of assisted suicide. Doctors have never been trained in assisted suicide and have no skills in this area. As stated above, we are competent in acts of omission of treatment, withdrawing of treatment and in symptom control. I believe a separate body would also allow doctors and patients to maintain the fundamental doctor patient relationship and ensure support could be given right until the end of a patient’s life, irrespective of the choices that they have made. This would be fundamentally different from the position achieved for many in relation to the Abortion Act and I also believe would prevent the legislative drift which has occurred with the Abortion Act. I believe a centrally controlled body, separate from the medical profession would provide a stronger and more robust framework for assisted suicide and one which could be much more clearly regulated. The medical profession would be able to provide medical reports for patients with their permission where required.

As stated previously, I welcome the opportunity to comment upon Ms Macdonald’s Bill as I think it also serves to highlight end of life issues in general. However, in terms of patient choice I believe this Bill will not improve equity in relation to end of life care. It will only improve choice in relation to assisted suicide for a confined group of people. There will be a large number of patients with progressive diseases who may not be eligible for assisted suicide. If we truly want to improve care at the end of life and take account of people’s autonomy and wishes, we should concentrate on considering the ability to use advanced directives, the new national DNACPR policy and the improvement in anticipatory care planning and transitional care planning as described in Living and Dying Well: a national action plan for palliative and end of life care in Scotland.

Thank you for the opportunity to comment on this Bill. I am willing to discuss further any of my views should this be required.

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