End of Life Assistance (Scotland) Bill

Dr Henry W Gray

Comments from Dr Henry W Gray, retired consultant Physician of Glasgow Royal Infirmary – worked in acute medicine for 42 years from 1965 to 2007.

Introduction

As a medical practitioner of 42 years standing, I would like to thoroughly object to this proposed legislation to legalise assisted suicide. I would like to articulate thoughts on the principle of the Bill, the Bill itself and finally the effects on the Medical Profession.

The Principle of the Bill

The idea that “I can do whatever I want with my own life and to blazes with the rest” is not surprising given the nature of our “I'll do it my way” culture in the UK. This grasping for a personal and complete autonomy from everyone else and especially from social norms, laws and customs is, I am sure, predicated upon the assumption of the originator that there will be no effect on other individuals by their autonomous action - which in this case is assisted suicide. Nothing is farther from the truth. By such an action, and over time, our law will become more vague, be exploited, and its aims and objectives changed radically from the originators ideals unless individuals with insight stand up and are counted. This has been amply confirmed in the UK where there is now abortion on demand, contrary to original intentions, and the Netherlands where there are now few controls on doctors who practice euthanasia.

Assisted suicide will have a major impact upon many individuals who surround the victim. From medical staff who prescribe and possibly administer the cocktail of drugs, pharmacy staff who dispense them and family members, some for and others against the whole concept of assisted suicide. Most impact would be on our ‘caring society’ where vulnerable individuals, particularly the disabled and aged, would see their doctor or even relatives in a different way. Those in society might well begin to worry that assisted suicide was being planned for them.

In effect, the desires of the few would begin to impact upon a huge number of the vulnerable in society worsening their quality of life through fearfulness and through a reduction of confidence in doctors who, up till now, have represented one of the trusted guardian groups of society.

As a consultant physician in general medicine, it has been my privilege to assist many adult individuals of all ages during the process of dying. I never ceased to be amazed at the courage and quiet dignity (i.e. the adjustment to the process of bodily functions running down) shown by the majority of these individuals. While I agree that the need for assistance with washing, feeding and toileting can at first seem difficult, the quiet dignity of personal character
seems to shine through despite their initial misgivings. I strongly suspect that a scrabbling around for evidence of the ‘intolerance’ of life would be experienced as more degrading than a little help at the end of life.

My daughter, Anne, aged 37 years, died of aggressive breast cancer two and a half years ago. She showed remarkable courage and determination to continue as close to normality as possible for her husband and three young children until a few days before her death. Her family doctor, the community nurse and the Marie Curie nurses were all magnificent and much appreciated both by Anne and the family. Her friends buckled down to child-care and providing food for the family at the end-time. This permitted our family to unite and feel loved at a time of great sadness. I fail to see how such an outpouring of generous love and concern for a family could follow the deliberate self-killing proposed in this bill. Indeed, I would suggest that one of the most undignified things possible is to be helped to commit suicide. Indeed, any mother deliberately ending her life is likely to be damaging psychologically for her children.

The Bill

I am not accustomed to reading legal documents but I recognise the vagueness that pervades this document and that concerns me. Even the title is surely incorrect. My daughter, Anne, was given end of life management (assistance) from medical and nursing staff and she died peacefully and naturally from terminal pneumonia. ‘End of life assistance’ in this Bill really means ‘assisted suicide’ or ‘euthanasia’ so surely it should be called that.

Clause 1
(1)(a) End of life assistance can be accessed already by modern techniques of Palliative Care.
(1)(b) I am concerned that ‘another person’ may assist the suicide. That person can be untrained and could suffer significant guilt thereafter.
(2) Why not use real words like assisted suicide and euthanasia. In my experience, patients retained a quiet dignity throughout their final illness helped by palliative care. Dignity is not the prerogative of euthanasia.

Clause 2
(1)(a and b) No professional body in medicine supports the Bill so few doctors would comply and there is no mention of a conscience clause for doctors. Striking, is it not, that there is no instruction for a difference of opinion between doctors.

Clause 4
(2)(a) In my practice as a hospital doctor, a terminal illness could last anything from days to years depending upon the pathology. Perhaps a definition is required. In a sense, we are all terminally ill with age.

I would not know how to assess ‘finding life intolerable’. It suggests a psychological element to the illness and is easily moderated with painkillers and or antidepressants.
(2)(b) I find this requirement extraordinary because, among the disabled, it will include the elderly in our society. If this Bill goes through, there could be pressure from family or society to ask for assisted suicide so as ‘not to be a burden’. My grandmother found life intolerable with osteoarthritis of both hips but stuck with it and enjoyed valuable relationships despite the considerable incapacity to later die in old age. How ‘intolerable’ has intolerable to be before it qualifies?

(4) Doctors cannot predict how long a person will live with any condition. Consider only a prominent Scottish prisoner repatriated to his home country recently.

Clause 6
(2)(a and b) How can any medical person possibly be sure that an individual, likely to be prescribed powerful drugs, understands that they are asking for euthanasia with a clear mind uninfluenced by pharmacy? How similarly can anyone be sure that influence has not been brought to bear on a person by family or by society?
(c) How can one measure and account for the disturbed emotion of illness (amenable to treatment), family pressure of which the client is ashamed/depressed but remains silent, physical pressure or coercion such as withholding the necessities of life such as food, sleep, company, love and finally, societal pressure from inadequate pension to an inadequate Health Service generating a felt duty to end their life.

Clause 7
(3) Surely ‘to the best of a psychiatrist’s knowledge and belief’ is inadequate given the gravity of what is proposed. What rigorous test is necessary to legally prove beyond doubt that the request is voluntary and made without undue influence? Also, what happens when practitioners disagree? Do the family trek round practitioners (doctor shopping) until they get a match?

Clause 11
(4) Would this mean that any person trained or untrained could assist with the suicide? What effect would it have on them? It could be traumatic!

The Medical Profession

The professional medical bodies including Royal Colleges and the British Medical Association have come out against the concept of assisted suicide or euthanasia.

The reasons are clear. Since the time of Hippocrates, medical practitioners have been honoured for always having the interests of their patients/clients at heart. In the Netherlands where euthanasia and now involuntary euthanasia is legal, only a tiny number of doctors are involved in the 4000 (in 1995) individuals killed each year. The problem is that up to 50% are without consent and it is clear that when the green light is given, abuses accumulate and increase (Jochenson and Keown J Med Ethics 1995). Indeed, the authors reported that the clear majority of cases of euthanasia or involuntary
euthanasia go unreported and unchecked. Clearly, there is no effective regulation in Holland and this is the model that this Scottish Bill is heading toward.

Dr Peggy Norris, chairwoman of the anti-euthanasia group Alert, said: "We need to learn from the Dutch system that euthanasia cannot be controlled." "I know of patients in a nursing home who are carrying around what they call sanctuary certificates all the time, stating that they do not want to be helped to die. People are afraid of being sick or of being knocked down in case a doctor takes the decision, without their permission, to stop treatment."

The Bill also raises questions for medical training. How and where would students or junior doctors be trained? Would there be a conscience clause for those against the practice?

After the trial and conviction of Harold Shipman, how would the general population view a doctor who has been trained to kill? This final question has been answered by the quotation from Dr Norris.

**Conclusion**

I am clearly against this Bill going ahead. My understanding is that despite Margo's own opinion, this Bill will reflect practice in the Netherlands rather than Oregon or Switzerland.

Most worrying for me is the scope of the proposal including those who are disabled or depressed and are therefore dependent upon others. The vulnerable of all ages including those with learning difficulties, personality disorders and psychosis, the demented or simply elderly will be at risk eventually. I have lived through the saga of Abortion law in the UK which started tight then the flood-gates opened. I have watched euthanasia in Holland progress to involuntary euthanasia where doctors are killing their patients without them knowing. It is ironic that we in the UK use ‘Do Not Resuscitate’ orders in case we are totally disabled when decisions have to be made about us in hospital while in the Netherlands, the patients use ‘Sanctuary Certificates’ to protect them from doctors. That tells us about the difference between our societies. Long may that difference continue.

I hope I never see the Dutch scenario in Scotland and would urge you to throw out this Bill.

Dr Henry W Gray
14 April 2010