Ojections to the End of Life Assistance (Scotland) Bill

1. The Bill avoids using straightforward terms to describe intentional killing of the patient, preferring the fudged phrase “end of life assistance”. It includes both euthanasia, where a physician kills a patient at their request, and assisted suicide where a patient is helped to kill themselves. By using the language of “free choice” and “dignity” people may fail to grasp that this Bill is more extensive than the Dutch euthanasia law and poses dangers to the welfare of not only the terminally ill but anyone over the age of 16 years with any chronic condition or disability who find life “intolerable”.

2. This sends a message to all disabled people and those with any chronic long standing disease such as severe diabetes, heart failure, respiratory disease or neurological disease that somehow because they are dependent on others they are of less value to society and so may feel obliged to choose euthanasia or assisted suicide.

3. That this Bill would apply to a 16 year old person is alarming, given that teenagers can make impulsive suicidal gestures.

4. “First do no harm” is a cornerstone of the healthcare professional’s duty of care, a duty which this Bill proposes can simply be waived in order that the patient’s life be ended. The importance of this paradigm shift in medical practice should not be underestimated.

5. The Bill is silent about the stresses involved in euthanasia and assisted suicide, or of the provision of any support for participating doctors and psychiatrists, nurse and pharmacists.

6. The Bill only mentions doctors and psychiatrists and does not acknowledge the involvement of nurses, pharmacists and administrative staff. The existence of a law permitting euthanasia would affect the efficient functioning of multidisciplinary teams as individuals might hold differing views on this emotional issue.

7. Euthanasia legislation has a potential to affect the trust between the doctor and patient. Such trust is essential for medical care, the present law recognises this and protects patients and society by making it clear that doctors are not permitted to intentionally kill a patient or to assist in their suicide but rather they have a duty of care to act in the patient’s best interests.

8. Once euthanasia and assisted suicide become legitimate treatment outcomes, doctors would be obliged to raise them as options with all dying patients.

9. The Bill does not provide for conscientious objection but suggests that an unwilling doctor must refer the patient to a colleague.

10. Relief of suffering is an important goal of medical care. However, there is no sort of care that could ever alleviate all suffering (especially some expressions of social, psychological and spiritual...
distress). The first step to addressing suffering is to ensure effective support in engaging with issues such as hopelessness, helplessness, loss of meaning and existential distress. Implementation of this Bill could increase suffering in vulnerable patients and their families by reducing trust, increasing fear and inhibiting patients from disclosing their concerns to doctors and other healthcare professionals.

The requests for euthanasia or assisted suicide have to be approved by a doctor. So the claim which this Bill makes for enhanced patient autonomy fails in the second clause of the Bill, as it is the doctor who has to decide if the patient is suffering enough. It is not possible for a doctor, or anyone else, to decide what is “intolerable” for an individual patient.

A single consultation with a patient could not possibly reveal all the factors behind a request for euthanasia or assisted suicide. It takes time to establish a sufficiently trusting relationship with a patient to allow discussion of these intimate concerns. Compounding the problem of a lack of time is the fact that many patients have a number of doctors and other healthcare professionals involved in their care.

The Bill makes no mention of what is to be done when the experts disagree in their assessments.

The first formal request may be considered by a doctor who may not have seen the patient before and has little idea about the nature and scope of palliative care. There is nothing in the Bill which would safeguard the vulnerable patient from this situation.

It is unclear what form the written formal request must take. Is it a personal statement or a standard form? An official tick box form could be coercive for some vulnerable patients.

The doctor will have to decide whether to provide conventional palliative care or advise the patient that they can initiate a formal request for euthanasia or assisted suicide.

The assessment of the euthanasia or assisted suicide request as envisaged in the Bill could create a barrier which subtly alters the doctor-patient relationship and paradoxically might impair the possibility of discussing the fears underlying the euthanasia request. It would be difficult to assess a patient’s needs when the goal of euthanasia dominates discussion.

The Bill permits patients to change practices during their 18 month residence in Scotland. This facilitates “doctor shopping” a phenomenon which occurs in Oregon by which patients find a doctor who will agree to their claim for assisted suicide.

The shortage of psychiatric services in Scotland means that in effect many patients will be forced to enter the private sector to have a realistic chance of a psychiatric assessment.

Psychiatrists have no wish to be gatekeepers for euthanasia, they strive to protect the vulnerable and prevent self harm. Screening for suicidal ideation and depression is not straightforward and the psychiatrist may have not be familiar with palliative care treatment options.
It would be difficult for psychiatrists, as for any doctor, to know the forms of end of life assistance available. Would underlying depression necessarily prevent the patient from receiving euthanasia?

Psychiatrists are not qualified to judge if the patient’s choice is influenced by others, the mere existence of a law permitting euthanasia is a statement by a society of the value it places on the chronically ill and disabled.

It is ironic that in 2002 the Scottish Executive launched “Choose Life” a national strategy and action plan to prevent suicide in Scotland.

The second psychiatric assessment may be carried out by the same psychiatrist, thus only two doctors need be involved in the whole process of euthanasia or assisted suicide.

The time limit of 28 days stipulated in the Bill seems to indicate that there is a rush to get the whole process over with as soon as possible. The time deadlines take no account of administrative delays which are part of the reality of the NHS. For instance, a secretary on holiday could mean that a patient had less than 28 days notice of the approval of their request.

Revocability of the request for euthanasia, means that the doctor must not kill the patient if he/she “gives notice, however informal” that they no longer wish to have their life ended. How is the doctor expected to interpret a sad expression or a throwaway remark as a sign that the patient does not want to be killed? Even patients who are determined to have euthanasia often change their minds. Yet if the doctor misses a subtle cue from the patient, all safeguards are useless. Some patients might feel inhibited about discussing their fears as these might be interpreted as a revocation. It is not clear in the Bill what happens if the patient expresses doubts or gives informal cues to a nurse or practice receptionist? Does this qualify as a revocation?

The requirements relating to the killing which is referred to as “assistance” are vague. It seems that whatever the patient and designated practitioner agree is permitted under the Bill. They can decide who carries out the killing and the method. There is nothing in the Bill which would prevent a member of the public helping a patient to hang herself or to slit their wrists in a warm bath. This lack of consideration of the practical implications for medical care in the real world pervades the whole of this proposed Bill.

Doctors are not trained to kill and do not have any knowledge of how to kill. How can they be qualified to discuss the choices of method with the patient? Would there now be a requirement to train doctors and students on how to kill patients? How would doctors respond to botched suicide attempts?

The designated practitioner must be present at the end of the patient’s life. This would be hard for any doctor to promise to be available at a time of the patient’s choosing. The doctor of course may not be the person carrying out the euthanasia. In Oregon the doctor was present at 30% of deaths initially but now attend only
4% of assisted suicide deaths. This is further evidence from Oregon that the “safeguards” are dropped as time passes.

30 Most people in Scotland die in hospital but the Bill does not mention how euthanasia will be carried out in hospital in “areas where there is no public access”.

31 Determining a prognosis of six months is impossible in many cases of life threatening illnesses. It is difficult in patients with cancer and even more difficult in patients with advanced heart failure, chronic lung disease or those with neurological diseases. Since much suffering can occur earlier in the course of an illness than the last six months, it is illogical to choose this arbitrary figure of six months if relief of suffering is the motive for this legislation.

32 If the patient did not want her family to know about the euthanasia or assisted suicide it would come as a huge shock to the family if euthanasia or assisted suicide was written on the death certificate.

33 What will be the effects on Scottish society of permitting euthanasia and assisted suicide and so weakening the prohibition against killing which currently protects us all? This legislation will change the way in which Scottish society views the sick, the disabled and the dying. There is a danger that such patients will be seen as an inconvenience to be disposed of. Patients might feel a burden to their families and society and obliged to consider euthanasia. There is much to learn about the impact of a patient’s social circumstances in generating a request for euthanasia or assisted suicide.

34 Any society which endorses euthanasia or assisted suicide is one which has less commitment to care of the dying. The countries which have legalised euthanasia or assisted suicide have low levels of palliative care provision compared to Scotland.

35 The Bill does not define a good death. It assumes that all euthanasia and assisted suicide deaths are peaceful and therefore “dignified”. It fails to mention that complications such as failure of completion, myoclonus and vomiting may occur in both assisted suicide and euthanasia resulting in suffering for patients.

36 There is little known about the longer term effects on the families of those who have had euthanasia.

37 The Financial Memorandum relating to the Bill suggests in para 97 “The costs required to deliver an assisted death will be minimal and will inevitably be less than those associated with providing ongoing medication and care”. This is a most chilling justification for this Bill; to link euthanasia and assisted suicide with cost savings in terminal care is shameful but may explain the real motive behind the resurgence of the debate in a time of economic recession. This is evidence of a slippery slope where those apparently arguing for the patient with intolerable suffering are in reality looking at a utilitarian solution for the convenience of everyone.

38 The financial memorandum claims that Heath Boards can meet the costs of this work within existing budgets. It is clear that the main extra workload will fall on primary care, although district nurses and pharmacists are not recognised as being involved in the process in
the Bill. The resource claims are based on an extrapolation of figures for assisted suicide in Oregon but this Bill is even more extensive than Dutch legislation, which permits euthanasia, so figures of cases of euthanasia and assisted suicide may be around 1000 a year in Scotland, not to mention the work involved in counselling those patients who make a request and subsequently change their minds.

39 It is possible to envisage a private practice operated by two doctors that effectively “rubber stamps” and complies with any request received for euthanasia or assisted suicide.

40 In 2005, the House of Lords Select Committee chaired by Lord Mackay of Clashfern spent six months meticulously reviewing the evidence on the legalisation of euthanasia and assisted suicide. The committee failed to reach a consensus but did agree some recommendations which any future legislation should take into account. This proposed Bill for Scotland ignores many of these recommended actions for example:

- A clear distinction should be drawn between assisted suicide and voluntary euthanasia.
- Any future bill should set out clearly the actions which a doctor may or may not take either in providing assistance with suicide or in administering voluntary euthanasia.
- If a future bill is to claim credibility that it is offering assistance with suicide or voluntary euthanasia as complementary rather than alternative to palliative care, it should consider how patients seeking to end their lives might experience such care before taking a final decision.
- Any new bill should not place on a physician with conscientious objection the duty to refer an applicant for assisted suicide or voluntary euthanasia to another physician without such objection.

Conclusions

The Bill is unsound and threatens the majority of vulnerable patients. It is damaging to the integrity of the medical and nursing professions. Poorly drafted, it displays a lack of understanding of the nature and scope of palliative care and threatens to undermine the progress in care of the dying that has occurred in Scotland over the past three decades.

Many of the viewpoints on both sides of the debate lack rigorous evidence to back their claims. We do not know what the effect this legislation will have on the doctor–patient relationship, the long term effects on bereaved families nor the factors influencing a patient’s decision making at the end of life. In the face of such uncertainty it would be foolish to risk altering the fundamental basis of medical and nursing practice to accommodate a tiny vocal minority whose heightened need to control threatens the care of hundreds of thousands of people in Scotland.

Dr David Jeffrey FRCPE
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