End of Life Assistance (Scotland) Bill

Dr Graham Keith

I have followed with interest the progress of Margo MacDonald’s Bill ever since it was announced in the media. As a lot of attention was given to Ms MacDonald’s own illness, I had understood the Bill would be designed to help those who were in an advanced state of some terminal and debilitating illness. I was ill prepared for the tone with which the Bill begins. It claims its purpose is “to permit assistance to be given to persons who wish their lives to be ended.” That simple sentence makes it clear that the Bill is proclaiming and trying to further a sea change in attitudes to life and death.

Though I am no lawyer, I had expected the legislation would begin in terms like this – “While it is a crime and will remain a crime punishable by law for anyone to assist another to die, there are a few circumstances which are exceptional and not deserving of prosecution. This Act will set out the parameters of these special circumstances.” By contrast, the purpose of the Act implies that it is quite natural for someone to wish to terminate his/her own life and that it is therefore acceptable to offer a person in such a state of mind appropriate assistance to carry out his/her wish. In short, if this Bill is accepted, we will as a nation be endorsing a culture of death.

The tone of the introduction is reinforced by the content of the Bill, most notably (a) by the vagueness of the categories who can apply for assistance in dying; and (b) by the complete absence in the Bill of any provision to monitor, review or even record what should happen if the Bill were to become law.

On (a) it is unsatisfactory that there is no definition of finding life ‘intolerable’. Without some attempt at definition the criterion must become entirely subjective – when a person declares that his/her life is intolerable, then it is. I am also amazed by the insertion of the category of those who are ‘permanently physically incapacitated to such an extent as not to be able to live independently’. That would embrace everyone in a Care Home, as well as a vast number outside of such Homes who rely on the care of relatives. Because of its vagueness and generality this may make many folk in Care Homes feel – rightly or wrongly – that they are under threat.

On (b) it is inadequate that a process of review by the Crown Office Procurator Fiscal Service should be mentioned only in the attached notes. This does not form part of the Bill itself. The process of physician assisted suicide in the US state of Oregon has come under severe criticism precisely because of the inadequacy of the steps taken to monitor what is actually going on. In theory this task has fallen to the Oregon Public Health Division (OPHD). But one study in a recent American law journal has found that the OPHD “does not collect the information it would need to effectively monitor the law and in its actions and publications acts as the defender of the law.

Clearly the Oregon position is unsatisfactory. But do we have any reason to think that the COPFS will be more thorough or critical in its work? After all, there is no legal obligation to give such cases much attention and, judging by the Explanatory Notes, no expectation that this will require much extra outlay in time or resources from the COPFS. This is a grave defect that must be addressed. It is no small matter to guarantee the genuineness of a voluntary, uncoerced profession of a wish to die. It demands much more rigorous policing than the Bill proposes.

I also have grave misgivings about the process. Firstly, both the medical practitioners and the psychiatrists are expected to go into all the options. This is laudable in theory, but I doubt if it will happen in practice. As it so happened, in the same week as I first perused the Bill I also read a report from *Which?* Magazine about a survey examining the reliability of the advice offered by High Street banks to those with savings to invest. The survey found that only 4 out of 37 banks properly adhered to the guidelines. Most fell short by leaving out some key area of advice. If there are currently grave deficiencies about advice on an issue like investment of money where the factors are relatively straightforward, how can we trust people to follow guidelines about the much more complex issues of the prognosis of disease and types of palliative medicine and healthcare – especially if there is no regulatory body to supervise this?

Then, there is the important question of the testimony which is to be provided by the medical practitioners, psychiatrists and independent witnesses. The medical practitioner is expected to express his satisfaction that the requesting person is making the request voluntarily and is not acting under any undue influence. I believe this is beyond the scope of the medical practitioner. After all, he/she is not trained as a detective able to expose all the twists and turns of family life. He/she cannot be expected to discern many subtle ways in which pressure may be exercised in a family context. Besides, some doctors are honest enough to say that they cannot be sure they can always detect an underlying depression induced by the illness and affecting the patient’s state of mind.

To turn to the role of the two independent witnesses, I suspect that if this Bill were to become law, this procedure would degenerate into farce. I would not be happy with anyone witnessing that I was voluntarily expressing a wish to die, unless they were part of my close family circle – and they are rightly debarred from acting as witnesses in this regard. Conversely, I could act only as a witness for other members of my own family circle, and again the Bill prohibits this. Who, then, is to act as a reliable witness? Are we to be content with the witness of a mate from the pub, the golf club or wherever? This aspect of the Bill will not only turn out to be an empty formality, but will contribute to decreased standards of public honesty, with folk being encouraged to bear witness to things beyond their power to attest.
A further and even more sinister twist is added to this issue when someone from a Care Home is allowed to bear witness to the death wish of a client. It takes no great stretch of the imagination to foresee situations where Care Home staff could subtly pressurise an awkward client into expressing a death wish and then attest that their client wants to die. Such a possibility would do much to undermine the relationship of trust on which a healthy atmosphere in Care Homes depends.

I am also amazed that the Bill contains no conscience clause to cover medical practitioners who do not want anything to do with assisted suicide for religious or moral reasons. I would anticipate that a number of doctors would have problems of conscience since a majority of doctors have regularly expressed their opposition to assisted suicide, and since the explanatory documents suggest that it will be ordinary GPs who face requests from their patients for assisted suicide.

Even if GPs had no conscience problems with the stipulations of this Bill, they would have to reckon with considerable additional workload. They would, if they did their job thoroughly, have to undertake these extra responsibilities –

- Investigating the home/Care Home background of the person requesting death
- Liaising closely with the psychiatrist
- Attesting the genuine independence and suitability of the two witnesses
- Providing suitable medical resources to help patients kill themselves.

This is a substantial extra burden, including (as I have pointed out) issues which really lie outside of medical competence. I am unimpressed by the way the Explanatory Notes gloss over this. Indeed, they make me suspicious that the Bill does not really expect the procedures to be followed thoroughly.

I am not surprised that in Oregon a large number of doctors play no part in assisted suicides and most assisted suicide deaths are facilitated by an assisted suicide advocacy group, Compassion and Choices (known formerly as The Hemlock Society). I suspect that if the Bill became law, we would see over time a similar development in Scotland with the emergence of a new breed of medical practice specialising in techniques of death and earning money from this. I draw this conclusion from the provisions under Section 4 (3), Section 5 (2b) and Section 11 (8). This would have serious consequences for the way in which medical practices and individual doctors are regarded in our society. Some at least would be seen as angels of death rather than helpers in life. And once such a perception had taken root, it would be hard to eradicate. That would be a major and unfortunate development which would affect the whole of society.

Nor can we overlook the question of resources. GP practices are increasingly having to develop skills in balancing budgets. In Oregon there have been well documented cases where patients were told that though drug treatments to combat or contain their illnesses were unavailable on the ground of cost, yet they could be offered the resources to enable them to die. Clearly this
scenario would not happen overnight in Scotland if the Bill were to become law, but what of ten years or so into the future when the debate over the Bill has subsided? Certain medical practices might deem it economically desirable to offer patients a quick death rather than to try to cure or stabilise the illness. I find little in the Bill which would encourage me to think we will be protected against such a development. My fears are heightened when I read in the Financial Memorandum – “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.” (Section 97)

I doubt even if there is adequate provision in the Bill to prevent Scotland from becoming a centre of suicide tourism. A spell of 18 months with a Scottish medical practice is far too short a period and even then there is no insistence that this be with the same practice. People with tenuous connections to Scotland – e.g. people who have studied here – could readily maintain links with a Scottish medical practice while effectively living and working elsewhere. More robust criteria are needed – e.g. five years’ residence in Scotland as attested by having their names on a Scottish voters roll.

Finally, I am astonished that there is no attempt to specify the means which can and cannot be used to assist death. But that is symptomatic of the Bill as a whole. The drafters of the Bill seem determined to provide maximum freedom to develop ways of assisting suicide for the relevant categories of people. At the same time they seem blind or indifferent to the very real dangers of abuse and propose only minimal safeguards.

I believe this Bill should be scrapped altogether. The supposed benefits for the few will be secured at the expense of considerable loss for the whole of society. For it will bring with it a changed perception of the medical profession; it will jeopardise the relationship between GPs and their patients; it will cast a cloud over the activities of even the brightest Care Home. Above all, it will change the perception of a wish to die as something abnormal and something like a cry for help into something that is normal and to be encouraged.

Should the Bill be retained, it requires much more detail and more rigorous safeguards. As it stands, it reads almost as a charter for those who promote assisted suicide to experiment unhindered.

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