End of Life Assistance (Scotland) Bill

Dr Elizabeth Swain MRCGP

You will be interested to know, perhaps, that we have had a discussion and teaching session in my Church (Kirkintilloch Baptist Church) specifically to address some of the issues of the Bill.

There was a wide interest in this and a considerable degree of unease at the implications enshrined in it.

I will try to condense some of the concerns of the group and of myself under the headings you have suggested.

- **Do you agree a person should be able to request end of life assistance from a registered medical practitioner?**
  - Issues that were raised as concerns under this category were the risk of coercion or the altruistic perception that one is being a burden to oneself, family and society.
  - The difficulty and failure even to attempt to define the word intolerable is open to abuse.
  - There were two people in the congregation who shared their own or their family’s experience where agreement under the terms of the bill would have been granted had the Bill been in existence a year ago and where now the so called intolerable situation has changed and these people are living fulfilled and dignified lives although their disease state has not been resolved.

- **Are you satisfied with the requirements for age and connection with Scotland as set out in the Bill?**
  - Personally I feel that at 16 one is too young and inexperienced in life to be able to make a rational decision of this magnitude. Teenagers are renowned for their sometimes hasty decisions and are of all of us the most altruistic and idealistic and could I fear fall prey to the feelings of “burdendom” I have mentioned above.

- **Are you satisfied with the two categories of people who would qualify to be assisted under the terms of the Bill?**
  - We are reassured that as we read the Bill the two categories give no scope for those with mental health illnesses to be included especially dementia. What assurance is there that in the situation of an advanced directive specifically requesting end of life assistance that this would not then be granted?

- **The Bill outlines a several stage consent and verification process that would be required to be followed for an eligible person to receive end of life assistance. Are you satisfied with this process?**
  - The process as outlined seems not to address the issue of medical staff who hold ethical or moral objections to the bill. There is we feel a
danger of a medical hierarchy of those who will agree to their involvement.

- We foresee the day when not just Drs and pharmacists would be drawn into this especially with the consent of the RCN to the bill. This has the danger of a further erosion of the trust in the Health Care professionals which is such an important part of good, effective and acceptable medical care.

- Do you consider the level and nature of safeguards as set out in the Bill to be appropriate?
  - As highlighted above with the two members of the congregation both of whose medical history I am aware of they would almost certainly have passed through the loops of the safeguards and would today be no longer with us....
  - My professional observation would be that psychiatrists are not the holders of all wisdom on whether a patient is emotionally in pain or has a mental illness. They would meet the patient de novo without the full background which a GP for instance may have access to.
  - The mere absence of mental illness is not the definition of emotional and mental wellbeing....

- Do you have any other considerations on the Bill not included in answers to the above questions?
  - My background is in General Practice with a special interest in Palliative Care. I work part time in a former Communist country with no palliative care services. The concept of PAS is never raised.
  - The concept of total pain of which psycho-spiritual pain is a significant part is not recognised as being resolvable by an acknowledgement of a combination of good palliative care and the understanding and acceptance of the need for spiritual care. Spiritual care is too often confused with religious care. The taking of a spiritual history is not being taught in the Scottish Medical schools and the exposure of medical students to palliative care is in some places rather limited. There is evidence that patients are not averse to the discussion of their psycho-spiritual needs and expectations and this is a potent means of giving hope in what many would see and define as an intolerable situation.
  - Dignity is a relatively newly taught concept in medical circles and the assumption in the Bill that dying is by definition an undignified process is naive.
  - The Church group did not consider that PAS was necessarily a dignified end to a life and some quoted a recent Utube video showing the workings of Dignitas as an example of an undignified death.
  - The evidence surrounding distress suggests that about 30% is due to pain, 30% due to other symptoms – in both these areas palliative care whether in the specialist services or in General Practice has a good track record of effectively – although sadly not always – dealing with these. Another 30% of distress is in the psycho-spiritual area and this may be addressed appropriately by those with adequate training – it is not rocket science...and experience.
• As a committed Christian the source of my hope and sustaining in times of difficulty is in Jesus Christ. Those of other faith groups also find solace in their religious faith. It is well documented that those with "a faith" are better able to cope with the stresses of dying.

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