End of Life Assistance (Scotland) Bill

Mr. Thomas Suslak

With regard to the End of Life Assistance (Scotland) Bill currently under discussion, a number of issues present themselves, to my mind. These include, but are not limited to, certain definitions and phrases included in the Bill which may be open to interpretation or ambiguity.

Firstly, clarification must be made to section 1(2) with regard the definition of “dignity and a minimum of distress”. The nature of death, being arranged, under later terms of this Bill, by conversation between the designated practitioner and the requesting person must be subjected to this initial condition. This statement must be clarified as a condition of assistance in the Bill and must impact any further considerations.

In addition, the Bill stipulates that requests for assistance must be made to a registered medical practitioner (2(1)(a)). The ambiguity of this paragraph offers the possibility for any practitioner to be consulted on this issue. This leaves open the potential for an inexperienced practitioner to be consulted. It may be prudent to include restrictions on the individuals qualified to be involved in the decision-making and advisory process in cases of end of life assistance. For example, it would be unwise to suggest that a junior doctor or even a specialist in a diverse or distinct field would necessarily have the expertise or authority to mediate appropriately in all such cases.

Furthermore, the Bill (2(2)) indicates that only one medical practitioner (excluding the psychiatrist) is required to be involved in the process. In decision processes of this level of importance it is unwise to leave judgements to one individual. It would be my recommendation that more than one practitioner is consulted throughout this process to avoid malpractice or misconduct that could result in erroneous premature death.

My next concern is with regard to the minimum age requirement stated in this act. It is a medically sound fact that, around the ages of 16-18, individuals are far more susceptible to mental instability and short-term depressive phases. The late-teenage years of an individual’s life are commonly associated with formative thoughts for later life, often involving some degree of depression or mental instability. This predisposition to mental instability heightens the likelihood that, in the event that the individual should suffer some medical condition that qualifies under the Bill, that individual would seek life-ending treatment where normally they would be disinclined to do so. Additionally, the minimum time-frame allowed under the Bill between initial consultation and treatment is insufficient to negate this effect.

The above point also highlights an issue with the condition that the patient “finds life intolerable” (4(2)(a and b)). What is the definition of an “intolerable” life? This is a purely subjective quality which cannot be effectively, externally assessed. Even with the inclusion of a psychiatrist in the process, there is no technique or mechanism which can determine a person’s assessment of their
quality of life. Furthermore, their assessment of their quality of life may be drastically distinct from a medical prognosis. This also raises the point that a patient may persistently only be able to make a short-term assessment of their quality of life (in the case of one eligible for end of life assistance under 4(2)(b)) without any consideration of potential longer-term applications.

Section 4(4) also further highlights the importance of including more than one practitioner in the decision-making process. It states that, in cases of terminally ill patients, the assessment of whether a condition is terminal relates to the life-expectancy of the patient that is “reasonably” expected. Immediately this implies informed and sound assessment of the case, which can only be made by practitioners who have been personally involved in the case in question (which may, therefore, also implicitly require further, external opinions as the practitioner responsible for a patient during a protracted illness may de facto become emotionally involved, to a degree).

When considering Section 5 (and other subsequent points of a similar nature to this one), clarification is needed of what “other interests” entail (5(1)(c)). Specification has already been made of financial grounds for disqualification as well as the relationship to the patient but is this qualifier inclusive of personal, emotional, territorial or other interests that may be taken into account? Also, if the individual concerned is unaware of any interest by where they stand to gain from the patient’s death (5(2)(a)) but this interest is highlighted, it would become necessary to ascertain the validity of the person’s unawareness of the interest and potentially replace the individual concerned in any aspect of the process, especially if that individual is one of the medical practitioners concerned.

Another point that merits amendment is in the list of individuals who may not witness the patient’s requests (6(4)) In addition to the designated practitioner being unable to witness the requests, the consulting psychiatrist should be unable to do likewise on similar grounds. It may also be necessary to further exclude any other medical practitioners who are brought into the consultation process.

Clarification is required on the exact methods of life-ending assistance that are legally provided for within the Bill. The current wording of the Bill does not specify which forms of assistance would be considered legal. The implications are that, although the common-sense interpretation would be for end of life assistance via medical intervention, the Bill seems to imply that a more literal construing of a “silver bullet” would also be acceptable if administered by a doctor (i.e. shooting).

Additionally, I feel an addendum is required to Section 9, subsection 3 to the effect that the psychiatrist’s report to the designated practitioner should also include reference to the patient’s response to the points raised as a result of 9(2)(e). This would enable corroboration with the practitioner’s own notes on the patient’s reasoning and enable the practitioner to more readily detect any hints of second thoughts, ulterior motives or even the presence of short-term, seasonally affected or other, non-chronic depressions, for example.
Penultimately, I would like to raise a concern with regard to the point that the decision to provide assistance is effective after “two clear days from the date of its conclusion” (10(3)). This means that life-ending assistance may be provided as soon as 48 hours after the agreement is made. This time-window is far too short should there be raised any concerns regarding irregularities in the whole procedure or other late-onset factors. This period should be extended to a minimum of seven days or a working week after the conclusion of formal proceedings.

Finally, in Section 12, “mental disorder” is clarified in relation to the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13). However, this Act does not include coverage of certain mental illnesses which may affect decision-making. These, as have already been alluded to, include seasonally-affected or other such short-term depressive disorders and similar conditions. As these are not classed under the Act as mental illnesses, they are not covered by this Bill as factors affecting judgement and discernment which could disqualify a candidate for life-ending assistance, despite the fact that the impairment to decision-making they impose are just as severe as those associated with the conditions which are listed in the Act. This inclusion needs to be made, especially in light of the point made above (paragraph 5).

In closing, I would like to add that, according to my own, personal beliefs; I consider it to be immoral to prematurely end a life (although I also consider it immoral to extend a life, artificially beyond its natural span). Whilst I respect the right of others to make their own choices, I would advise anyone against the premature taking of life or ending of their own. Following on from this, I do not agree that it is acceptable to place on physicians or any medical professional the burden of deciding to end the life of an individual in undue course, which contravenes basic medical codes of conduct: to preserve life and treat illnesses (with silver bullets if available, but not in a literal sense).

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