End of Life Assistance (Scotland) Bill

M Branthwaite

1. Agree end of life assistance should be available but question the propriety of the decision lying wholly within the remit of medical practitioner(s). Not all practitioners are willing to participate, for professional as well as personal reasons. A ‘conscience’ clause as suggested in the corresponding English Bill introduced by Lord Joffe, was considered insufficient protection, even if there was no obligation to refer to a willing practitioner. A default position of non-participation would be preferable so that willing practitioners could ‘opt in’ rather than ‘opt out’. (But see also my comments in para 6).

2. Age 16 seems very young for a decision of this magnitude but I accept the need for a threshold age and agree the residency qualification.

3. Very supportive of the suggested categories of eligible persons.

4. Not satisfied with the process – cumbersome and impractical.
   - s6(1)(b) must specify how to authorise if patient cannot write
   - s7(1)(b) not satisfied all practitioners can advise re palliative care
   - s7(2)(d) who arranges the psychiatric consultations?
     - psychiatric consultation not mandatory for patients who wish to withhold or withdraw consent to life-sustaining treatment
   - s9(1) very onerous to insist on two psychiatric consultations
   - s9(2)(b) psychiatrists not necessarily familiar with palliative care
   - s9(2)(d) psychiatrists possibly unfamiliar with available methods
   - s11(2) getting through the process quite onerous so requirement to complete within fixed period – or else face going through it all again – is applying covert pressure (cf Oregon where only about 2/3rds of prescriptions are used).
   - s11(6) Dr needed to certify death, not necessarily be present

5. Safeguards must ensure three preconditions are fulfilled: capacity, a voluntary act not clouded by treatable depression, and explanation offered for why that individual considers his/her predicament intolerable. All are covered by the proposals but the entire process of both decision making and implementing the decision rests on the medical practitioner(s). I regard this as unacceptable for both practitioners and for society as a whole, especially as the Bill would permit administration of lethal medication in circumstances where the patient is unable to self-administer (s1(2)).

6. An alternative approach could be based upon existing principles and procedure for contentious end-of-life decision making. Thus (a) competent adults are entitled to withhold or withdraw consent to life-sustaining treatment; the cause of death is deemed to be the life-threatening illness, not either suicide, or homicide by those withdrawing the treatment.
the courts can and do authorise withholding or withdrawing life-
sustaining treatment from incompetent persons if, on the basis of evidence, 
such action is deemed to be in the best interests of that individual. 
These principles could be applied to competent adults, acting voluntarily, who 
 wish for assistance to end their lives because they consider this to be in their 
on best interests. In essence, a court-based system is advocated by which 
the patient would apply for what could be termed ‘a compassionate end-of-life 
declaration’ authorising that patient to seek appropriate assistance from a 
will ing practitioner. In England, the Court of Protection might be a suitable 
forum. A two-stage procedure would be preferable, the initial stage requiring 
the patient to adduce evidence that they were competent, acting voluntarily 
and able to offer reasons for reaching the decision, the second stage being an 
application to register the intention to act upon the declaration, including 
details of the assisting person. The certified cause of death should indicate 
that this was an assisted death consequent upon the underlying condition 
which prompted the patient so to act. Such a system 
(a) would separate the roles of decision making and implementation; 
(b) would use the rightful role of the law in determining situations where 
there is potential conflict between the interests of society and an individual; 
(c) would avoid the present discrimination whereby a competent adult 
refusing life-sustaining treatment is deemed to have died from the underlying 
disease, whereas a subject with a similar condition not requiring life-
sustaining treatment is deemed to have committed suicide from poisoning if 
an assisted death is secured eg at Dignitas, and those assisting in even 
ancillary roles are at risk of prosecution, a risk which remains unresolved until 
after the death.

M Branthwaite 
3 May 2010