While this evidence may not represent the views of all of the staff members within the Faculty it presents some concerns that have been raised regarding the proposed Bill.

As suggested in the response guidance this evidence is structured to answer the questions that all responses are meant to address in the sequence suggested:

Do you agree a person should be able to request end of life assistance from a registered medical practitioner?

In principle, yes. However, we have reservations about the Bill and what it proposes. We recognise the right of individuals to choose what is right for them, but have concerns about how those people who fall into the two eligible categories may reach their decision to end their lives.

Are you satisfied with the requirements for age and connection with Scotland as set out in the Bill?

Overall we are satisfied with the requirements regarding the connection with Scotland, and with the age requirement. The reason that we are satisfied relates to the provision within the act that all persons making a request to have end of life assistance has their capacity to make that decision assessed. There are a number of people in very vulnerable groups within our society who may wish to make use of this law, so assessment of capacity for all who make such a request would be an essential requirement of any legislation that follows.

Are you satisfied with the two categories of people who would qualify to be assisted under the terms of the Bill?

Although in principle the Bill embraces the two groups most likely to seek end of life assistance there are problems regarding using the adjective “intolerable”. The term is very subjective, and by its very nature it allows people to describe why they find something intolerable. It is possible then that by detailing what is intolerable, actions could be taken to relieve the situation. We would hope that all of the potential actions would have been exhausted prior to a first request to designated practitioner, in order that end of life assistance was not an unduly lengthy process.
The Bill outlines a two-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?

See our above answer. We do believe in the principle that it should be a 2 stage process giving the person time to reflect on the request that they have made and allowing a suitable time period for them to withdraw from it, if they so choose.

Do you consider the level and nature of safeguards as set out in the Bill to be appropriate?

The safeguards surrounding the medical staff that may be involved in the procedure seem to be appropriate. An improved understanding of what an assisted death might entail might help the person become sufficiently informed to make a fully competent decision, therefore, some guidance regarding what method of death constitutes one that preserves dignity could perhaps be made more explicit within the Bill. Ultimately though, the nature of the death will be a decision arrived at by both the person and their “designated practitioner”.

Another concern relates to the public’s awareness of other end of life services. The Scottish Government in Living and Dying Well (2008) pointed to the underutilisation of hospice services by those with life-limiting illnesses that do not have cancer. It suggests a cohesive and collaborative approach to the development and maintenance of equitable, high quality and sustainable palliative and end of life care services based on the principles of equality, dignity and quality. Extending and improving palliative and hospice care, so that it fully embraces all the people covered within this Bill who may seek to end their own lives would have a significant impact on the number of people likely to make use of the services that this Bill would create. Allowing “End of Life Assistance”, should not be seen by either the public or those who face death or life altering incapacity as an alternative to improved access and use of both palliative care and hospice services.

Despite this above point, it has to be recognised that not everyone would want to receive such services and if they do wish to have control over the end of their life then they should have the right to ask for assistance and those providing it lawfully should be protected from prosecution.

Do you have any other considerations on the Bill not included in answers to the above questions?

A substantial number of people now and into the future will end their lives in care homes. While the Bill does consider the position of those living in care homes, and care home staff may seem to be well placed to act as witness to the person’s request to end their life, it should be noted that the length of time that older care home residents spend in the homes is reducing and this trend is continuing. Many older people enter care homes in circumstances in which they are already vulnerable. This set of circumstances may make it very
difficult to ascertain why the current situation is deemed intolerable. The Scottish Commission for the Regulation of Care (2009) in “Better Care Every Step of the Way” again point to a need to make improvements to Scottish Care Homes’ abilities to provide better palliative and end of life care. We would endorse this position. The Care Commission and Mental Welfare Commission for Scotland (2009) In “Remember I’m Still Me” stated that around 70% of people living in the care homes they visited had varying degrees and types of dementia but only 24% people had an adequate record of their life history (which may have included their diagnosis). It is important therefore to again stress the need for assessment of capacity in all cases in order to safeguard the person’s “best interests”.

We also have some concern regarding the place where end of life assistance will be provided and related to this, the cost of payment for assisted death. There is a risk that in order to provide this service for the people who might be interested that the service will be provided in a single unit supervised by a number of practitioners who may deal with all second requests. Many GP’s and many Psychiatrists may have sound ethical and moral reasons not to wish to be involved in what in effect is life ending treatment which may lead to a few medical professionals and their associated teams dealing with many of the cases that come forward. Would our NHS be in danger of creating its own NHS “Dignitas” clinic and is this desirable? What safeguards exist to prevent this?

The Explanatory Notes suggest that if the “Oregon” Model is followed in Scotland, potentially 55 people per year would end their life through the use of the Act, which may result from this Bill. While the Explanatory notes suggest that the Crown Office Procurator Fiscal Service would have the power to investigate any deaths which give rise to public concern, what safeguards will NHS Scotland have in place to monitor and investigate the use of this service?

As with any changes in medical treatment or healthcare there is the potential that the promotion of assisted suicide might be fuelled by an economic agenda. Assisted suicide has the potential to save NHS Scotland and Local Authority Social Care Services a substantial amount of money that would otherwise be used to provide continuing care and palliative care to this vulnerable group of people. What safeguards are in place to ensure that this does not occur and that the service, should it become available remains appropriate to the needs of the two groups who might currently use it?

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6 May 2010