End of Life Assistance (Scotland) Bill

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The issue of Assisted Dying/Physician Assisted Dying/Euthanasia is really all one. It boils down to this: does society have a part to play in the ending of anyone’s life.

Society’s responsibility is to help people to live, not die. The duty of the state is to protect life. These are overriding principles that have shaped our civilisation. It is insufficient reason to help people to die just because it is time-consuming, difficult and expensive to help them to live. In the 21st century, the improvements in palliative medicine make it more possible than ever before to give people requiring care more dignity in living until they die naturally. End of life issues in Scotland are better dealt with by the provision of more care, not less. If assisted dying is legalised, the incentive for creative caring will decrease.

The Right to Die runs the proven risk of becoming a Duty to Die. Many elderly people already feel a burden to family, carers and a society which is cost conscious and short of resources. They may feel pressure, real or imagined, to request assisted dying. Baroness Finlay of Llandaff was quoted in Hansard (6 June 2003) as saying 'A sense of a duty to die is all too easy to create and all too difficult to detect.'

In Oregon, Physician Assisted Suicide (PAS) was legalized in 1997. A recent survey found that, with the increasing acceptance of PAS, the percentage of patients who died through PAS because they felt a burden to others (not necessarily the only reason, however) increased from 12% in 1998 to 26% in 1999 and to 63% in 2000. (Sullivan AD et al. Legalized physician-assisted suicide in Oregon, 1998-2000. New England Journal of Medicine 2001; 344: 605-607.)

When Oregon legalized PAS, only a minority of patients requested PAS because they felt a burden to others. However, with the increasing acceptance of PAS, nearly two-thirds of those dying through PAS cite being a burden to family, friends or caregivers as one of the main reasons for requesting PAS. I believe that the Bill is vague in its wording and dangerously broad in its scope. There is no definition of what makes life “intolerable”. Therefore, both the request for, and the acquiescence in, Assisted Death must be subjective. One or more doctors will inevitably end up making a value judgment, which they should not make, as to whether a patient's quality of life is such as to warrant preserving or terminating his or her life. That being the case, this Bill puts the most vulnerable members of society at great risk. The German physician Christoph William Hufeland wrote in 1806: 'It is not up to [the doctor] whether life is happy or unhappy, worth while or not, and should he incorporate these perspectives into his trade the doctor could well become the most dangerous person in the state.' (quoted in WJ Smith. Forced Exit. Spence Publishing, Dallas 2003. p84.)
The provision of medical support to the sick has always been based on a relationship of trust between the sick and the medical practitioner. This bill would fundamentally alter that relationship. The Dr is a healer of life, not a terminator of life. This Bill would authorise/require Drs to provide and administer the means to end life. The Bill is flawed because it does not allow a Dr who conscientiously objects to Assisted Suicide to opt out of it. What justice is there in overriding the right of someone not to take life, with a legal requirement to make them do so? This Bill is fundamentally flawed in that there is no obligation on Drs participating in Assisted Suicide/Euthanasia to report their involvement. Therefore it will be well nigh impossible to audit the operation of the Bill, or to check on its use and/or abuse.

The actions envisaged under this Bill would need the strongest possible controls. The Dutch experience should be a warning to us: it is documented that Dutch doctors currently only report half of all cases of Physician Assisted Suicide/Assisted Dying/Euthanasia to the authorities. With such a low rate of reporting, Dutch claims of adequate control ring hollow. In a recent analysis, the notification rate increased from 18% in 1990 to 45% in 1995 to 54% in 2001. Asked why doctors did not report cases of Assisted Dying/Euthanasia to the authorities – even though they were required to do so by law – doctors responded that this requirement was considered burdensome and time consuming. More worrying obviously would be the possibility that patients had been 'euthanised' by doctors in violation of the regulations and the cases were not reported in order to avoid criminal prosecutions. (Onwuteaka-Philipsen, BD et al. Dutch experience of monitoring euthanasia. British Medical Journal 2005; 331: 691–3)

In conclusion, The End of Life Assistance (Scotland) Bill, whilst purporting to increase choice of care for the very sick, in fact represents a failure of care to the most vulnerable in society. The Bill lacks adequate safeguards and checks. It places the vulnerable at greater risk of being pressurised to request Assisted Suicide or of being killed against their will. The Bill would fundamentally alter the relationship between Drs and patients. The Bill is a classic thin end of the wedge as seen in the reports on the operation of similar measures in Holland and Oregon, USA

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