End of Life Assistance (Scotland) Bill

Peter J Helms

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

No. Doctors are committed to curing disease (if possible) to help relieve suffering and and to honestly discuss treatment options in a partnership of trust. The option of prescribing or giving medicines to end a patients life endangers this trust. People in distress and/or fearful of the future must have confidence that their Doctors have their best interests at heart. The practice and promotion of Palliative care could also be threatened by such legislation. Furthermore it is not clear what is meant by “appropriate means”. Doctors in Scotland are not involved in the practice of deliberately ending life and ensuring that death occurs within a few minutes of drug administration. If enacted this bill would require training for Doctors in ensuring a rapid death, would require a revision of GMC guidance for Doctors and could result in a small group of Doctors taking on this work not previously known to the patient. The prospect of including such training in Scottish medical schools but not in other medical schools in the UK would also be problematic and could result in reduction of movement of students and Doctors from other parts of the UK to Scotland while encouraging Doctors from the few countries where such legislation is enacted to move to Scotland.

Provision for a dignified death at home or hospital or elsewhere is already available, although could always be improved, and is recommended in “Living and dying well”. The proposed legislation could have the effect of reducing demand for and for improvements in palliative care. I note the economic argument for actively ending life in the supporting material.

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

No. Many young people in their teenage years are still maturing physically and emotionally and suicide is recognised as a major concern at this age of transition to adulthood. The legislation proposed would give the wrong message to young people in emotional difficulties and particularly those coping with the additional burden of chronic progressive disease. Legislation although designed to be accessible only to defined groups could have the effect of encouraging young people without end stage disease to go ahead with suicide. Establishing the principle of Doctor assisted suicide and/or direct killing by Doctors in law could have the effect of reinforcing the appropriateness of suicide in those contemplating this option for themselves.

3. Are you satisfied with the two categories of people who would qualify to be assisted under the terms of the Bill?
No. The bill goes far beyond previous attempts at legislation by including individuals with permanent physical incapacity. This would make the legislation the most permissive in any country and hence questions estimates of numbers of eligible people based on data from the few countries where assisted suicide and/or euthanasia are available.

For the first category ie those with terminal illness and in pain this legislation could as pointed put above threaten the development and extension of palliative care and the principles enshrined in “Living and dying well”. Palliative care always be improved, needs to be made more widely available and better funded and is a better fit for the practice of medicine and the relationship of trust between Doctors health care professionals and patients than what is proposed here.

4. 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?

No This could result in the death of a requesting individual within a few weeks of initial approach to a Doctor. Prediction of life expectancy is always difficult, and individuals with physical incapacity experience periods of distress and can take many months and years to come to terms with their disability. It is frequently the fear of pain and uncertainty about the future that influences individuals in their views of self worth and tolerability and this fear is what good palliative care seeks to address. The proposed legislation runs counter to recent developments in equality of access and participation of individuals with physical handicap.

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

No. The short time between initial approach and delivery of death and the difficulties in excluding overt or implicit pressure from individuals and from public expectations are major concerns. Revocation is poorly defined and is open to interpretation.

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

The subject of death and dying is never and easy subject to discuss and consider and hence it will always be difficult to identify a true majority public view on legislation such as proposed here. The carefully considered arguments for and against will always be dominated by those with strong secular and religious views and beliefs. Choices and legal options which benefit one section of the population can inadvertently adversely affect others such as may happen in this case. Present legislation on assisted suicide and active killing safeguards the vulnerable and will punish those found guilty of its promotion. However attenuating circumstances are taken into account in the application of present law. Replacing current protections and careful post hoc
examination of the circumstances with a proposal with many ambiguities and problems in interpretation seems unwise.

This proposed legislation also runs counter to recent developments in equality of access and participation of individuals with physical handicap. Legislating for the few actively requesting this change in the law and presenting this as an extension of choice and the appropriate exercise of autonomy is just as likely to impair autonomy in the many who would be eligible. Furthermore it stands the risk of adversely affecting the Doctor patient relationship. Surely the principle of “do no harm” needs to be considered here.

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