End of Life Assistance (Scotland) Bill

St Columba’s Hospice

St Columba’s Hospice provides Specialist Palliative Care to patients with active progressive, far advanced illness. The focus of care is based on providing the best possible quality of life for each patient as well as offering support to their families, carers and friends.

Complex symptom control is an extremely important focus in the care of our patients; however, we take a much broader view by addressing physical, psychological, emotional, social and spiritual needs.

On average 30-40% of our in-patients are able to return home once symptom control has been achieved.

We provide a 30 bed in-patient unit, a Day Hospice service, which includes Complementary Therapy, and a Community Palliative Care Service delivered by Specialist Nurses who support and advise the Primary Care Team in enabling people to stay at home.

We also provide education and training on Palliative Care to both post and under graduate students from all disciplines in Health Care: medical, nursing, physiotherapy, occupational therapy, social work, pharmacy and ministers of religion, enabling Healthcare staff to care for people in the future.

We provide education courses for Health Professionals as recommended by ‘Living & Dying Well’, thereby supporting the Scottish Government’s emphasis on a “cohesive and collaborative approach to the development and maintenance of equitable, high quality and sustainable palliative and end of life care services for the future” (Living & Dying Well 2008).

As a specialist palliative care service we are constantly seeking to maintain and improve the quality of the services we provide to our patients.

We would like to comment on the “End of Life Assistance (Scotland)” Bill and its accompanying notes.

Issues for Consideration by MSPs

Terminology

The title of this proposed Bill “End of Life Assistance” is misleading. End of Life Assistance in the sense of caring for and supporting patients at the end of life is already provided by Palliative Care Services, but active termination of life plays no part in this care. The Bill title should state clearly what is intended by the Bill.
It is fundamental to Palliative Care that practitioners explore the needs and wishes of patients as the end of life approaches, aiming to assist them as they die from their illness with dignity and a minimum of distress. Health Care Professionals (practitioners) may also discuss a patient’s feelings of hopelessness in order to be able to explore the causes of those feelings of distress and hence plan care to meet the patient’s needs. This process may involve exploring with the patient whether they are having suicidal thoughts or thoughts about whether life is worth living. It would be easy, given the imprecise terminology used by the Bill, for patients involved in such exploration to believe that a practitioner was proposing euthanasia or assisted suicide when this was not the case (and for them to reach the potentially devastating conclusion that their doctor did not believe their life was worth continuing).

The Bill does not distinguish between ‘assisted suicide’ and voluntary euthanasia and the uninformed are unlikely to notice this: therefore this distinction should have been made explicit.

**Eligibility**

To allow a decision regarding such a profound issue to be taken at the age of 16, when thought processes are underdeveloped is very worrying. There is no mention of parental input.

For many medical conditions, particularly non-malignant diseases, to determine a prognosis of less than 6 months is extremely difficult.

The reference to being “incapacitated and unable to live independently” could refer to patients with a wide range of medical conditions/disabilities: people with the mildest form of disability could be at risk and some may feel that assisted dying is something that they should explore.

**Safeguards**

Many physicians are likely to opt out of this legislation, therefore it is quite likely that the ‘designated practitioner’ will not know the patient. It is also almost certain that the psychiatrist will not know the patient; psychiatry resources are already stretched and patients might have a significant wait to see a psychiatrist.

The patient must sign the request. Many patients, nearing the end of life, do not have this ability. There are no provisions within the Bill for this.

There is no mention of family views or wishes, therefore consideration should be given to the grief reaction of those ‘left behind’ and the support they will need.

What are the implications of ‘assisted suicide’ on an individual’s life insurance? Will it still be honoured by an insurance company?
**Assistance**

The Bill is vague in discussing the form and means of assistance and assumes that doctors would know what to do: this is not true. Neither is it explicit as to who will provide this assistance, nor who will provide the education and training.

**Costs**

The Bill makes mention of ‘reasonable fees’, indicating that availability of assistance may depend on whether the patient could afford this. It is possible that provision of this service could be a method of income generation for ‘designated experts’ and therefore could lead to a significant conflict of interest.

The explanatory notes state “the costs required to deliver an assisted death will be minimal and will inevitably be less than those associated with providing ongoing medication and care”. This should be considered in the context that the old and vulnerable in society may consider that they will cost less to their families and society by taking this route, again re-enforcing the view that they have little worth.

**Comparison with other legislation**

Estimates of numbers of assisted deaths are based on comparisons with legislation in Oregon. However, Oregon does not allow assisted death for patients with permanent physical incapacity. It is impossible to know, therefore, whether the estimates for the proposed Bill are in any way accurate.

**Conclusion**

This proposed Bill lacks the clarity and detail necessary to introduce a responsible change to the law. It is ambiguous and statements are made in the explanatory notes which show no evidence.

The Bill shows a lack of knowledge of Palliative Care and what our specialists are able to provide patients with advanced progressive disease. Following the reading of this Bill the reader is left with many more questions than answers.

Laws should be changed to address a real need and to protect the public.

We request the committee’s consideration of our observations and suggest that this proposed Bill is rejected

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10 May 2010                                10 May 2010