End of Life Assistance (Scotland) Bill
Dr Bruce Cleminson

I am Dr. Bruce Cleminson, NHS GP at Scalloway, Shetland from June 1979 to March 2008, GP trainer from 1985 to 2008, and Macmillan GP for Shetland from 1999 to 2008. In my role as a GP, I was involved in the care of about 180 people who died with cancer over a period of almost 29 years, as well as many more - possibly 600 or so - who died of other conditions ending with a terminal illness. In my role as Macmillan GP for Shetland I was involved in Palliative Care Education as well as the planning of Cancer Services for Shetland.

I am concerned by this bill. I would like to mention just a few areas about which I feel comment should be made, and share my thoughts and feelings having read the ‘End of Life Assistance (Scotland ) Bill’.

Autonomy

Much is made in our generation of autonomy –a person’s right to choose - in this case choose when and how to die.

But … my autonomy affects other people around me.

Firstly, the family and friends. Already, it is recognised that the families of those committing suicide often bear a burden of guilt that they failed to meet the needs of the person who has taken their own life. It is likely that the same feelings will be felt when the family member or friend chooses assisted suicide.

Then, the health care professionals. These people help patients to respond to and overcome many medical and life crises over many years. These same professionals are now to be asked to supply the medicines required to kill the patient, who they have worked with, up to this time, to help overcome his or her difficulties.

Also, society at large. We rightly hold human life as very precious and that killing is not appropriate for any of us to do, apart from in times of war when defending our land and our people. Now, we are giving the message that killing is OK after all, in certain other circumstances. We risk brutalising our society - to think less highly of human life.

On the elderly. The elderly may get the message that, at the end of life, it may be appropriate to shorten their lives for some reason. A person may feel that their life is “intolerable”, but once there is “a line in the sand”, this line can be moved and the elderly can be made to feel that they should opt for an early death for a variety of reasons – this has been reported in Holland since they allowed voluntary euthanasia. The elderly may also begin to feel insecure – what if their GP thinks that their lives are not of high quality – could he end their lives without permission? Of course, the Margo Madonald’s speaks only
of voluntary decisions to shorten life, but then so did the Dutch Euthanasia legislation, and yet, in 1990, the Dutch authorities reported that, despite it being totally outside the legislation, about 1000 patients had been killed without their permission - involuntary euthanasia. It was found that many elderly Dutch folk were becoming worried about whether they could trust their GP any more.

In addition, there may be pressures from family and society for an elderly person to opt for a shortened life – and these have been reported from the Dutch experience – which means that the decision is less voluntary than, at first, we are led to believe. Voluntary decision making means that the patient and family need accurate and full information about the likely course of the illness and the available alternative options to choosing Assisted Suicide. The doctor discussing assisted suicide should explain all the available options – but will the doctor who is to do this explanation be experienced enough in the alternatives to give accurate and full information about these options? The evidence shows that the more that doctors and others in the caring team know about palliative care, and the more they have been involved in giving such care, the less convinced they are that the options of assisted suicide and euthanasia are needed as reasonable choices. The very doctors who are best suited to tell what the real alternative options are – what quality palliative care offers - are much less likely to be in favour of assisted suicide and euthanasia. So the doctors involved in this provision of assisted suicide, and so discussing these issues with the patient are likely to be those who are less experienced in providing palliative care and so less informed about what good palliative care can do! Not surprisingly, where there is excellence in palliative care, there is a much lower rate of asking for Assisted Suicide or Euthanasia - the ones being treated by the doctors and nurses best able to tell the benefits are the ones less likely to ask.

Suffering – and how it’s treatment can change patients and families perspectives

Sheila Hancock – her mother died from cancer, in hospital, in the early 70s in terrible distress. Her first husband died of cancer several years later, but was treated by the St. Christopher’s Hospice team in London. Pain and symptoms were so well controlled, and other needs were met so well, that Sheila Hancock and her husband were able to go out to the West End for an “evening out” on the evening before her husband died. His quality of life was good, and any distress was minimised.

Victor Zorza – this Polish Journalist, living in the UK, had the sadness of finding that his daughter was dying of Cancer. She had a terrible experience in the NHS, but was then transferred to Sir Michael Sobell House in Oxford – the local hospice – where the quality of care, under Dr. Robert Twycross, transformed the last week of her life. So affected was the father – Victor Zorza – that he determined to go back to St Petersburg, where he had sought refuge from the Nazi’s during World War 2, when Poland was invaded. There, he had seen people dying of cancer in unrelieved suffering, and so he wanted, after his daughter’s death in the early 1980s, to go back and share with the
people there about what palliative care can do. So, "hospice care" reached Russia, because of the transforming effect that it had had on the lives of the Zorza family and the despair they had felt.

**What about non-cancer terminal illness?**

These two examples are of people dying of cancer, and it was in the realm of far advanced cancer that Dr. Cicely Saunders began her work in relieving the pain and distress amongst those who were dying. It has been shown that the same kinds of symptoms affect many of those dying of other illnesses, and the same approaches are effective in understanding the problems and in attempting to bring relief in such situations.

**There are other aspects;**

- **The difficulty of making diagnoses** – some that we think are dying of cancer are, in fact, do not have cancer at all; Others who we think are untreatable can, sometimes, with good supportive care, improve to the point where they can benefit from more curative forms of therapy.

- **The slippery slope** – it has been clearly documented in Holland that what started out as permission to kill in very carefully prescribed circumstances, led to an uncontrolled and poorly recorded procedure. The careful rules about repeated asking and verification by two doctors were commonly not complied with, and the Dutch law society, in 1990, concluded that euthanasia was now operating in an uncontrolled fashion. Even the reporting was incomplete as, despite the law permitting euthanasia; commonly the doctors still wrote up the death as being from “natural causes" as this was more acceptable for the families concerned.

In Britain, after the 1967 abortion act, we saw the same incremental changes happening in relation to the interpretation of the allowable reasons for abortion, leading effectively to ‘abortion on demand’, although the 1967 law was very clear about the allowable indications. David Steele, in the 1967 parliamentary debate at Westminster, had given assurances that abortion on demand was not the intention of the act.

- **The conscience clause** – a “conscience clause" was included in the 1967 abortion bill, but in reality worked differently to the intention. It meant that, commonly, at interviews for gynaecology posts, the attitude of the applicants was asked about abortion, and the doctors who were against it on conscience grounds were not appointed.

This was denied, but, several years ago, was clearly shown to be the case with the case of Dr. Everett Julyan in Glasgow. When he challenged the reasons for the Glasgow Hospitals for not appointing him as an SHO in Gynaecology, it was demonstrated that he was not appointed solely because of his unwillingness to be involved in terminations.
So far there is no mention of a conscience clause in this bill – a serious omission – even if the conscience clauses in other bills have not always worked as intended.

**Dying with dignity** – dying with dignity appears not to be related to whether a person has chosen when and how to die. Assisted Suicide or Euthanasia deaths are not necessarily “dignified” or even comfortable just because of those choices. Good palliative care can help to make deaths, which happen at their natural time, as dignified and comfortable as they possibly can be.

**Refusing treatment vs giving a lethal medication.** Some people have expressed discomfort that a person may instruct “no resuscitation” in certain circumstances, but cannot request to have this or her life to be shortened when the person concerned judges it to be intolerable. There never has been compulsion for patients to accept treatments intended to help them just because they are available – any patient is allowed to accept or refuse treatments that are on offer. No treatment offers 100% success, and most have possibilities of being ineffective or even making things worse, and so people have choice in what treatments they wish to accept or decline. Refusing a treatment that is offered to help someone to recover or to reduce pain or suffering is entirely different to giving one that is intended to kill.

The word **compassion** – “com-passion” means “suffering with”, not killing.

**Summing up,** I think that I can understand why people are pressing for assisted suicide. However, my opinion is that the help that they hope for from this legislation would come at a cost to others, especially the vulnerable and elderly, who would be put under pressures as described above to end their lives prematurely, and the balance for society would be negative not positive.

I feel that to invest in good quality palliative care – in education and training for doctors, nurses and carers as well as equipment that will enable them to do the job well – is the way forward – not legislating for assisted suicide.

I feel that Assisted Suicide should not be made available in Scotland or elsewhere in the UK.

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