Overview

It is part of the professional responsibility of any doctor looking after patients with terminal illness or severe physical incapacity to engage in a full and informed discussion on this important issue, which I believe will be legislated for in our working lifetime. I would suggest that the invitation to comment be extended to as wide a membership as possible of the RCGP and the other medical Colleges, to generate as representative a sample of views as possible on this topic.

Assisted dying, and the legal, ethical and practical issues surrounding it has been the subject of media attention for some years. This has been mostly for the patients making the request, rather than the health professionals who would be providing the service.

Public awareness has been further raised in 2010, with author Terry Pratchett, who has a form of Alzheimer’s Disease, using this year’s Richard Dimbleby lecture as a forum to propose the setting up of euthanasia tribunals to assess individual’s requests for an assisted death. I am writing this document in response to Margo MacDonald’s proposal for new legislation in Scotland allowing assisted death under certain conditions, according to the terms of the End of Life Assistance (Scotland) Bill.

Opinion polls would suggest that the British public is generally in support of having this choice at the end of life. The British Social Attitudes Survey has asked about euthanasia on several occasions, and has consistently found support for doctors being able, at the patients’ request, to end the life of a patient with a painful incurable disease subject to safeguards (77% support in 1983, 75% support in 1984, 79% support in 1989 and 82% support in 1994)\(^i\). An ICM survey in March 2006 and a YouGov survey in May 2006 had similar findings, with the Scottish public reporting higher levels of support than the British public as a whole\(^ii\). When asked who they would wish to provide this service, the majority stated they would wish it to be their general practitioner.

Conversely, the traditional stance of the BMA and RCGP has been opposition to legalization of assisted dying. But do these official stances still represent the views of their members in 2010? An informed discussion on this Bill must be encouraged in the current context, taking into account factors as the progressive advancement of life-prolonging medical technology and treatments, the increasing emphasis on patient autonomy (in medical student teaching, junior doctor training, the public consciousness, and court decisions) and our ageing population. The fastest population increase according to the
Office for National Statistics in 2009, has been in the number of people aged 85 and over, the “oldest old”, corresponding with a rise in the incidence of age-related degenerative conditions.

End of Life Assistance (Scotland) Bill

In response to the specific points that the Committee has requested we consider:

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

   Yes.

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

   Yes, it would only be appropriate for adults to request the service and not those under the age of 16. The requirement for a person to have been registered with a medical practice for a minimum of 18 months seems reasonable to prevent health tourism across the border, particularly if there is to be no additional funding available to provide the service.

3. **Are you satisfied with the 2 categories of people who would qualify to be assisted under the terms of the Bill?**

   Category 1: “As well as having a terminal illness the person will also have to find their life to be intolerable”

   Category 2: “Persons who are permanently physically incapacitated to such an extent as to not be able to live independently and who find life intolerable”

   The criteria of those suffering from terminal illness (death expected within 6 months) and permanent physical incapacity are criteria that could be defined with reasonable certainty.

   However the caveat that any persons falling within these criteria must also be shown to be experiencing “intolerable suffering” will be very difficult to assess objectively. Although the Bill proposes that this will be explored through formal psychiatric assessment, the final decision will rest with individual clinical judgment and may be open to interpretation. A more explicit criterion may be “untreatable suffering” which requires an assessment of whether all reasonable medical measures to treat suffering, physical or psychological, have been considered (similar to previous concerns regarding wording in Lord Joffe’s Assisted Dying for the Terminally Ill Bill in 2004).
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?

In addition to the eligibility criteria for persons requesting assistance as set out in Q3, there are also eligibility criteria for the witnesses and the registered medical practitioner in that none may be a spouse, relative or stand to benefit directly or indirectly from the person’s estate (similar to the requirements for a property will).

The person is required to make 2 separate formal requests for assistance; written, specific, signed by the person in the presence of 2 witnesses. The first request is assessed by the registered medical practitioner (RMP), a general practitioner, and a full discussion of all end of life care options are discussed. The 3 criteria for informed consent must be met; competence (as assessed by an independent psychiatrist after both formal requests) informed, and voluntary (as assessed by the RMP). The second request is to the same RMP within 30 days. If the request is accepted this must be in writing an the assistance with dying would take place within 28 days.

Although the proposed Bill is consistent with the necessary principle of informed consent on behalf of the person, and impartiality on behalf of the witnesses and doctors, I have a number of practical concerns.

i. A single medical practitioner (with the aid of a psychiatric report) makes the final decision on whether to proceed with an assisted death; similar medico-legal scenarios, such as cremation, or termination of pregnancy require a second opinion, at the very least

ii. The timing of the formal requests and the administration of end of life assistance is likely to be impracticable, with a 2 month maximum time period from the initiation to completion of the process.

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

In principle, yes.

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

i. Although the costs of providing this service through primary care are predicted to be negligible, and able to be subsumed within the existing budget, this is highly unlikely. Discussion and assessments of this nature are time consuming, as would be the requirement to be present at the time of death, either at the person’s home, or their chosen place, and will require either additional funding or removal of resources from elsewhere in the
primary care budget. If this is not made explicit, GPs may be more likely to opt out of providing the service, under the auspices of conscientious objection.

ii. The proposed Bill suggests that persons wishing an assisted death would make the request to their own GP or GP practice. I suspect that the numbers of GPs who wish to opt out of providing this service on conscientious grounds may be high, and that if patients are required to make requests to individual RMPs that they may have to register with a different practice which would not be consistent with good palliative care.

iii. If the numbers of persons making the request are predicted to be small, it may be more appropriate to have a dedicated “team” of GPs, trained in the necessary procedures to run the service to ensure that skills are expertise are kept up to date.

iv. But I would suggest that rather than having individual cases being heard and decided on by individual RMPs, that they are heard by a selected panel or tribunal of trained experts, which may include at the very least 2 GPs (one known to the patient) a psychiatrist, a medical lawyer and a lay person. A representative from palliative care or the appropriate specialist for the person’s condition may also be considered. The benefit of this system would be more transparency and equity and impartiality in the eyes of the public and fellow professionals. We cannot underestimate the impact that the previous high media profile medical scandals have had on the perception of the doctor-patient relationship, particularly post Shipman.

v. It may also be beneficial to consider whether the “assistance” needs to be provided by a doctor or whether this could be a trained technician, following medical assessment for eligibility. This may have a less damaging effect on the wider doctor-patient relationship.

vi. I would suggest that the wording of the Bill be more explicit; rather than End of Life Assistance (Scotland) Bill which does not describe accurately what it is legislating for, perhaps the Assisted Dying (Scotland) Bill.

vii. An appeals process may also need to be considered when the decision taken by the RMP is to decline the request.

viii. Training for those doctors involved in the process is proposed to be provided through NHS Education for Scotland, although, again these predicted costs are minimized. If assisted dying is legalized in the UK, this will be a new procedure for all involved and will require the necessary training in all aspects including the assessment process, safety procedures, record keeping and notification (to the procurator fiscal) and ongoing psychological support.
ix. The Bill is not explicit in whether it proposes to legalise assisted dying (the physician provides the means of dying only, usually by means of a prescription) or euthanasia (the physician brings about the death itself, usually by lethal injection). It could be argued that there are important moral differences between these options, and opinion polls of doctors suggest more support for assisted dying than euthanasia itself. This would need to be clarified to allow informed debate within the profession.

x. Finally, I would propose that this is an ideal time to consider putting patient advance directives on a statutory footing. These documents, written at time when a person is competent to express their wishes about what they would wish to receive or refuse in terms of medical treatment at the end of their life, come into effect when a person loses capacity, thus extending their autonomy as far as possible. Although these documents are legally binding in Scotland if they adhere to certain criteria (evidence of informed consent, up to date, signed, witnessed and applicable to the circumstances that subsequently arise) this is under common law only, as it was omitted from the Adults with Incapacity (Scotland) Act 2000. The equivalent legislation in England and Wales, the Mental Capacity Act 2005, specifically covers the requirements for a legally binding advance directive, making the situation clearer for patients and their treating doctors. I would propose that the Adults with Incapacity Act be amended to allow statutory guidelines for Scotland, as part of the Scottish Government’s commitment to improving legislation on end of life care. This is an area in which I have a particular interest and I would be happy to discuss this further.

Dr Carey Lunan
MRCGP MPhil (Law and Ethics in Medicine)
11 May 2010

i http://www.guardian.co.uk/society/2010/feb/02/terry-pratchett-assisted-suicide-tribunal

ii http://www.ukpollingreport.co.uk/blog/archives/212

iii The ICM survey (March 2006) asked the following question: “Do you think that, provided there are strict safeguards, if a competent terminally ill person asks for it, a doctor should ever be allowed by law to prescribe for the patient life-ending medication that the patient then takes to end his or her own life?” 71% of total respondents agreed, whilst the Scottish figure was 83%. The YouGov survey (May 2006) asked the following question: “Do you think the law should be changed to allow such patients to receive a prescription from their doctor to end their suffering, subject to a range of safeguards?” 76% of total respondents agreed, whilst the Scottish figure was 78%;
