I’m writing as a junior doctor, to express my deep concerns about the proposed “Right to Die” act.

Do you agree that a person should be able to request end of life assistance from a registered medical professional?

My two concerns are about the patients who will request this and the effect on the medical profession’s relationship with our patients and the public.

I am particularly concerned by the risk to vulnerable patients that this bill would pose. The bill attempts to safeguard against undue influence by asking two medical professionals and two witnesses to attest that the person has not come under “undue coercion.” However, a far more common situation is one where someone who requires physical care (or is no longer able to work) feels themselves to be a burden on their family. In a survey examining attitudes of patients cared for in a Canadian Hospice, 80% agreed that “cancer patients become a heavy burden on their families.” The same survey found that the strength of this belief and the strength of religious affiliation were the only factors to predict a patient’s desire for physician assisted dying or euthanasia. Attitudes were not related to symptom severity or experience of family members with cancer.

Another study by Kelly et al found that the factors associated with the patient’s wish for hastened death included depressive symptoms, a higher perceived burden on others, lower family cohesion, a positive attitude on the doctor’s part towards physician assisted suicide, the doctor having less training in psychotherapy and their perception of more emotional distress and less optimism in the patient. A third study again found little connection between pain and the likelihood of an expressed wish for hastened death, but a strong relationship with low social support and depression.

If the individuals expressing a wish for death in these studies were interviewed, it is unlikely that they would identify their lower social and family support as a factor in their desire for death. For them, the decisive element in their decisions is their new experience of limiting illness. It is only when populations are examined that it becomes clear that the truly toxic factors are sociological and personal. This disconnection between the individual’s rationale and the strong, unidentified influence of social factors makes discriminating between individuals on the grounds of their illness perilous.

An alternative angle on the value placed on life by those who are terminally ill is brought out by a technique commonly used in health economics: the time trade off. In this, an individual is asked what period of their lifespan they would be willing to “trade off” in order to secure a return to full health. Values produced for different conditions are highly counter-intuitive. Women with
menopausal problems, for example, were willing to trade many years for symptomatic relief. Many patients with symptomatic, metastatic cancer (cancer which has spread beyond the original site), meanwhile, refused to trade a single day. (This proportion was sufficient to give this condition a value equivalent to perfect quality of life in one sample.) Interestingly, relatives and professionals were willing to trade off a greater amount of time on the patient’s behalf than the patient themselves was willing to trade. This suggests that they perceived the patient’s quality of life as being worth less to the patient than did the patient. This incongruity is another potential source of unintentional influence on the patient’s decision to request physician assisted suicide.

One danger of legalising physician assisted dying is, that as the concept becomes more socially acceptable, it may easily becomes easier for those struggling with new physical limitations and a change in their role to perceive requesting it as an expectation upon them (however far this may be from reality or their family’s intent.)

Although Ms MacDonald’s policy memo dismisses the possibility of euthanasia being extended beyond the groups initially designated, the example of the Netherlands (a mature, liberal democracy) shows troubling parallels. A proportion of cases are now non-voluntary (in very young, disabled or demented patients who are not deemed capable of making the decision). One study reviewed “end of life decisions” in patients with mental handicap. In discussing reason for making life-shortening decisions, doctors and the authors referred to “non-autonomous requests” and “non-verbal communication” indicating that the patient assented to hastened death. These included asking to be left alone, and refusing medical intervention. Neither of these behaviours would be particularly abnormal in a population with learning disabilities and in only of these two cases had the proposition been discussed with the patient themself.

An additional concern is that suicidality fluctuates. This is most obvious following a diagnosis or injury, where there is a well-described pathway (not necessarily sequential) of denial, anger, bargaining, depression and eventual acceptance. This pattern can repeat with future set-backs. Even among those who are not going through an adjustment reaction, it is a recognised clinical phenomenon that patients who have made a genuine decision to kill themselves may genuinely change their mind and present for medical attention after an overdose. These patients may have hoarded medication for some time with the settled intention of suicide, but decide they wish to live on experiencing the reality of their overdose. Obviously, those receiving physician-assisted suicide would be unlikely to have the opportunity to change their mind after the event.

My second main concern is for the effect this bill would have on the medical profession, and on our relationship with our most vulnerable patients. As a doctor, my duty to promote life, and to promote the fullest life possible, is fundamental to my interactions with my patients. This does not exclude empathising with the difficulties faced by disabled and terminally ill patients,
but it means that my role in the situation is work to with them to maximise their current well-being in a holistic manner, often by referral to other specialities or other agencies (such as social work, voluntary groups or a chaplain.) Requesting a hastened death is different from requesting a medical procedure, and requires examination as a statement of distress\(^\text{10}\). In many ways, the safety provided by the patient knowing that I cannot help them to kill themselves allows a fuller discussion of their distress and difficulties.

Often patients who come into hospital are acutely confused or are suffering severe mental illness. One of the advantages we currently have in dealing with these patients is that doctors are generally associated with healing. If this association becomes tainted with a role in facilitating death, then our ability to comfort and reassure these patients will suffer.

There are further concerns with the individual effects of physician assisted suicide. Endowing a “right to die” on a patient, creates a responsibility for their doctor to kill them if requested in accordance with the law. The current bill does not specify how doctors would seek to exempt themselves on ground of conscience. Further, while the bill envisions a death that is “humane and must minimise distress,” in reality, an audit of physician assisted suicide in the Netherlands\(^\text{11}\) found that in 16% of cases there were problems in “completion” (a longer than expected time to death, failure to induce coma or the patient awakening after coma was induced.)

On a broader philosophical point, most of the debate surrounding euthanasia and physician assisted suicide presumes that the choice for the patient lies between positive suffering and a state of non-being. Although the belief in life as non-existence is common among professionals, over 70% of the population identify themselves as belonging to a religious tradition which posits the existence of life after death\(^\text{12}\) (whether in the form of reincarnation or an afterlife) which could either be better or worse than the patient’s current state. The comparison between death and life is therefore not one between the patient’s current state and a null, but between the patient’s current state and an unknown.

Finally, any legislation which opens the possibility of death as an outcome reduces the incentive to explore all possible options to alleviate the patient’s condition. Although the bill places a duty on the psychiatrist and medical practitioner (which is assumed to usually be the patient’s general practitioner), they will not necessarily have the specialist knowledge to explore all the possibilities that palliative care, social services and voluntary and religious organisations can offer. Suffering in patients should be a spur to better, and more creative care; not simply to allowing them to die. Cost implications should not affect the care offered to patients, but they will always do so, and vulnerable and elderly patients are the most likely to worry about the costs posed to the NHS by their own care.
Are you satisfied with the requirements for age and connection with Scotland as set out in the Bill?

I am concerned that the age has been set at 16: an age at which people are considered too young to smoke or drink.

Are you satisfied with the two categories of people who would qualify to be assisted under the terms of the Bill?

I am concerned that the criteria for the second category are excessively loose. Although the political memo states that "old age is not a qualifying condition to receive an assisted death," a large proportion of elderly people have some physical impairment requiring some support. "Not living independently" is not defined in the act, and it is not certain whether it would include, for example, a weekly home help, a carer to help with tablets or a regular visit from the district nurse to provide dressings.

I’m also concerned that there is no minimum time from diagnosis or acquiring the impairment to allow for the normal process of adjustment.

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?

I feel that the safeguards in the act derive from a simplistic view of undue influence. The most likely danger, and one which would be difficult to identify, would come from caring families. This would be posed both by the patient’s own guilt at taking up the time of their loved ones, and from knowing that their disability or symptoms cause their family distress. Relatives and professionals have been shown to rate patients’ quality of life as lower than the patients themselves, and it is difficult for the patient not to absorb these attitudes.

There is a further difficulty that patients do not always find it possible to be completely honest with doctors. Natural reserve, nervousness, a desire for privacy, and a fear of being judged or denied their wish can all prevent them communicating fully. Often it takes a series of assessments for patients to be able to be open about their fears, motivation and feelings.

The length and number of appointments which would constitute a psychiatric assessment is not stipulated in the bill. I am also concerned that there is not definition of what is meant by the stipulation that “all other alternatives must have been explored.”

In conclusion, although I recognise the genuine desire to help those who are suffering intolerably, I feel that the risks posed to vulnerable individuals and to the role of the medical profession by this bill are too great to allow it to pass.

Dr Jenny Bryden
11 May 2010
References


10 Muskin P. The Request to die: role for a psychodynamic perspective on physician-assisted suicide. JAMA. 1998; 279; 323-328
