About St Andrew’s Hospice

St Andrew’s Hospice has been caring for the people of Lanarkshire since it was founded in 1986 by the Sisters of Charity. It provides specialist palliative care services and provides care of patients with progressive disease and limited prognosis including physical, emotional, psychological and spiritual care. The Hospice is open to all without distinction of race, gender or creed. It has grown in the past 25 years to support the needs of the community and it now offers:

- 30 bedded specialist palliative care unit
- 2 bed respite care service
- A day hospice offering care for up to sixty patients every week
- A care at home service, for those patients who chose to want to die at home.
- A specialist range of support services
- A consultant led domiciliary service
- Three symptom management clinics per week
- A telephone palliative care advice line
- An education service to support the understanding of palliative care in Lanarkshire.
- The involvement of the hospice medical staff in palliative care provision in the three District General Hospitals and clinics across the county.

St Andrew’s Hospice is recognised as a registered charity by the Office of the Scottish Charity Regulator (OSCR). (Charity no: SC010159).

In April 2006, the hospice became a company limited by guarantee with charitable status and changed its formal name to become St Andrew’s Hospice (Lanarkshire). In its day-to-day business, however, it retains the operational name of St Andrew’s Hospice.

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- Provides relief from pain and other distressing symptoms;
- Affirms life and regards dying as a normal process;
- Intends neither to hasten or postpone death;
- Integrates the psychological and spiritual aspects of patient care;
- Offers a support system to help patients live as actively as possible until death;
• Offers a support system to help the family cope during the patient’s illness and in their own bereavement;
• Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
• Will enhance quality of life, and may also positively influence the course of illness;
• Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications."

Specialist palliative care focuses on people with complex palliative care needs (e.g., complex pain management or psychological support) and is provided by a team of professionals who specialise in palliative care (e.g., consultants in palliative medicine and clinical nurse specialists in palliative care). General palliative care forms part of the routine care of patients and support for carers. It may be part of the work of a range of health and social care practitioners including GP’s, care assistants and hospital staff.

Management Team & Medical Staff Response to the End of Life Assistance (Scotland) Bill

We have concerns about the title of this Bill; The End of Life Assistance (Scotland) Bill. From the title at the start and throughout we feel that this Bill uses language in a misleading way. End of life assistance is provided by specialist and general palliative care practitioner teams by means of high quality symptom management (emotional, physical and spiritual). It is not intended to shorten life but to alleviate suffering. Therefore, we feel that the term “end of life assistance” has been hijacked by this Bill possibly to disguise its real aim, which is to legalise the intentional ending of life by either assisted suicide or euthanasia.

The Bill states that end of life assistance means including the provision or administration of appropriate means to enable a person to die with dignity and the minimum of distress. We feel that the word dignity has been used inappropriately. There is no attempt to define what is meant by dignity or a dignified death. However, there is a heavy suggestion that dignity is something, which people can clearly identify with and clearly define and that assisted dying will always be dignified. We would suggest that a dignified death is very difficult to define; it is very subjective. We feel that most people have a good and dignified death. We suggest that these emotive and subjective terms should not be used in this Bill.

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

This Bill requires two formal requests in order for assisted suicide/euthanasia to be provided and it is suggested that these requests be made to a registered medical practitioner and that these requests have to be approved by that practitioner. As far as we can see, an assumption has been made that the
medical establishment in Scotland would agree to engage with this process. As far as we are aware, the medical profession has not been consulted on this Bill and we feel that it is presumptuous for authors of the Bill to assume that doctors will become involved. The medical profession exists to treat, cure and care for sick and disabled people. There are many who feel that doctors should stay clear of assisted suicide or, more accurately, of putting people to death if they want to retain the trust of their patients. If doctors were given the option to end life, the doctor/patient relationship would never be the same again. It is a fundamental part of specialist palliative care that medical staff explores physical, emotional and spiritual symptoms at the end of life, with the aim of assisting patients to die with the minimum of distress. These discussions may be emotionally charged and it would be easy, given the ambiguous terminology used by this Bill, for patients to arrive at the conclusion that their doctor was suggesting euthanasia or assisted suicide when this was not the case. Therefore, we do not agree a person should be able to request end of life assistance from a registered medical practitioner.

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

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

Eligibility in this Bill includes anybody over sixteen years of age who has been diagnosed as terminally ill and finds life intolerable, or is permanently physically incapacitated to such an extent as not to be able to live independently and finds life intolerable. We are concerned that the word “intolerable” may be subject to wide interpretation. Also the phrase “incapacitated to such an extent as not to be able to live independently” is capable of widely varying interpretations. The above leaves the scope of the proposed legislation extremely unclear, for both professionals and persons seeking voluntary euthanasia/assisted suicide.

We ask MSPs to consider how this Bill, if introduced, will impact on Scotland’s National Suicide Prevention Strategy and Action Plan “Choose Life”, with its aim of reducing the suicide rate in Scotland by 20% by 2013 and which is supported by the government. In particular, MSPs are asked to take account of the age qualification of this Bill (sixteen years) and the real possibility that the Bill would allow assisted suicide for young, impressionable, vulnerable teenagers with ill-defined “capacity” and with subjective feelings of their lives being “intolerable”. What signal would this Bill send to the wider, young population of this country? Therefore, we are not satisfied with the requirements for age as set out in this Bill and we are extremely dissatisfied with the two categories of people who would qualify to be assisted under the terms of this Bill.
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?
Do you consider the level and nature of safeguards, as set out in the Bill, to be appropriate?

Section 6 (2) of the Bill states that witnesses must sign a statement that, to the best of the witnesses knowledge and belief: the requesting person understands the nature of the request, is making the request voluntarily and is not acting under any influence in making the request. We would be very concerned as to the reliability of these witness statements as numerous subtle pressures may be brought to bear on an individual who requests assisted suicide, which may escape anything but the most rigorous of scrutiny.

Section 7 (1) of the Bill states that before determining whether or not to approve the first formal request for end of life assistance, the designated practitioner must physically meet with the requesting person and discuss with that person; the medical condition referred to in section 4 (2); all feasible alternatives to end of life assistance, including hospice care and palliative care where relevant; the nature and consequences of the request including its revocability and the forms of end of life assistance which may be provided. We are concerned that the designated practitioner, who is likely to be a GP, may not have a suitable range of knowledge about palliative care and may therefore be ill equipped to provide appropriate advice to a patient who is seeking assisted suicide or euthanasia. This is also likely to be the case at the mandatory psychiatric interviews. Thus there is a real danger that all feasible alternatives may not be fully discussed.

In section 9 (1) and (2), it is apparent that the role of the psychiatrist is to consider the capacity of the applicant and not to provide a psychiatric report. This is of concern to us as a treatable depression occurs in over a third of patients with advanced progressive disease. However, the assessments required in this Bill do not include mandatory screening for depression.

There is no mention in the Bill about the level of seniority required by the designated practitioner and the psychiatrist who will be carrying out these assessments. It is of great concern that a junior, inexperienced member of the team may become involved. The fact that modern healthcare is practised in teams is completely overlooked in this Bill. The potential role of and impact on these professionals, including: nurses, pharmacists, social workers and chaplains are ignored.

The Bill is completely silent on the forms of end of life assistance, which may be provided. In addition to the ambiguous title of the Bill, such a stark lack of detail serves to further sanitise it. We would suggest that it is very difficult to comment adequately on safeguards without knowing the process in its entirety. However, we feel that the level and nature of safeguards, as set out in the Bill, are not appropriate and we have grave concerns about the consent and verification process.
Summary: (Other considerations on the Bill not included above)

The Management Team and medical staff at St Andrew’s Hospice believe that moves to legalise assisted suicide and euthanasia, such as this Bill, stem from fear in a small section of the population, of possible future adverse health related events and the concern that appropriate care and support may not be readily available. We believe that these fears should continue to be addressed by ensuring that palliative care and support, both specialist and non-specialist, is made available for all in Scotland. It is our experience that patients in a caring environment, who have their concerns adequately addressed, do not ask for euthanasia or assisted suicide. It is worth repeating that depression, often the root cause of patients feeling that their lives are no longer worth living, is treatable.

We feel that this is a poorly drafted Bill, which makes use of many emotive terms; it is extremely light on controls and assumes the support and involvement of medical staff. The Bill uses ambiguous terminology and hijacks words, which are used by organisations that do not support deliberate killing. This Bill appears to have been created for the few at the expense of the many: The many frail, vulnerable patients that we care for across a broad spectrum of age who are in danger of viewing the medical profession with fear and suspicion should this Bill be introduced. If this law reaches the statute book, there is a very real danger of it causing collateral damage well beyond the intended target area. The Bill does not explore the impact of euthanasia/assisted suicide on individuals, families, carers, clinical staff and society as a whole. The Bill implies that those who do not support it are showing no mercy and support for its introduction comes from a few opinion polls. However, the reality of working with people at the end of their lives shows that the experience of living with end of life issues is very different from abstract discussion when death and dying is distant. In other words, opinion polls have little or no bearing on the reality. Public opinion favours such legislation, but how well informed are the public about the ethical, medical and legal complexities and the practical implications, including the effect on families? This Bill makes assumptions about a doctor’s role in the deliberate ending of life but it is silent on conscientious objectors. St Andrew’s Hospice has had extensive experience of patients who have found life, at certain stages of their illness, intolerable. With multidisciplinary input and support, we have seen that quality of life improve, sometimes dramatically. The Management Team and medical staff at St Andrew’s Hospice believe that life is precious and oppose the End of Life Assistance (Scotland) Bill.

Postscript

A private members Bill that would have legalised euthanasia and assisted suicide in Canada, was strongly defeated by a vote of 228 to 59 recently. It was recognised that many people raised legitimate concerns and the goals now are to work with Canadian leaders to identify ways to:

- Improve palliative and hospice care throughout Canada
- To change attitudes and improve services for people with disabilities
• To institute an effective national suicide prevention strategy in Canada
• To promote programmes that identify and eliminate the scourge of elder abuse

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Saint Andrew’s Hospice
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