End of Life Assistance (Scotland) Bill
Dr Angela Bentley

Objections to End of Life Assistance (Scotland) Bill

Physician assisted suicide and voluntary euthanasia fundamentally alter the doctor-patient relationship, turning it from a partnership to a contract where the patient dictates medical treatment. Whilst respecting patient’s autonomy has a high ethical priority there are limits to individual autonomy if it threatens the autonomy of other members of the community. There is a danger that care of the dying, disabled and elderly will slip down society’s priorities, if a cheaper and convenient option is available. Once an option then those people who felt themselves to be an emotional or financial burden on others may well feel obliged to request physician assisted suicide or voluntary euthanasia. Over recent years, there has been much progress in the care of the dying in this country, which would be threatened by this Bill.

Comments

General

The scope of the Bill is very far reaching and includes people who are not in the last 6 months of life and would include the frail elderly and the physically disabled.

The wording of the Bill is often confusing, and it has hi-jacked the language of palliative care. It should be noted that the Bill makes no reference to the terms euthanasia, voluntary euthanasia, suicide, assisted suicide or physician assisted suicide.

It is alarming how few safeguards there are in place to protect both the rights of patients and of physicians. The Bill makes no mention on arrangements for reporting, monitoring or reviewing arrangements where “end of life assistance” has been provided. There is mention in the explanatory notes, but not in the Bill, that the Procurator Fiscal Service would consider each case of an assisted death, but post-mortem review seems unduly lax, when it is difficult to rectify disputes/conflicting opinions etc.

There is no mention in the Bill about arrangements for medical staff or others involved in the process for refusing to participate on grounds of conscience.

Specifics

1. “end of life assistance” is defined as enabling a “person to die with dignity and minimum distress”. This aim is that of palliative care. The difference is that palliative care also aims to “help you live until you die” (Dame Cecily Saunders).
The term “assistance” is not defined and is a more palatable term to encompass “voluntary euthanasia” and “physician assisted suicide”. It could be argued that the term “assistance” has been used to mislead the public as to its real meaning. The Bill is about deliberate acts to end life, not about assisting in the natural dying process, which may be assumed from the term “assistance”.

Given that “end of life assistance” is so vaguely defined, it is unclear as to whether it provides any protection against a charge of murder.

2. Requests need to be made to a “registered medical practitioner”
If any registered medical practitioner can approve this process, any medical practitioner who could be approached will have to have specific training in this area.

4. Eligibility requirement
   (1) (a) It seems perverse that if this Bill came into force that a 16 year old could choose to be killed, but could not vote in local or parliamentary elections.

   (2) (a)(b) The term “intolerable” is not defined in the Bill and open to huge range of interpretations.

   (2) (b) With the progress that the Disability movement has made over the years, fighting for equal rights for people with disability this Bill seems a very retrograde step for disability rights. “not able to live independently” is also a very broad statement, which could include all those who require any personal care, however low-level. It would include frail, elderly people.

   (3) It would be very easy for non-residents of Scotland to register and move their registration around, in order to qualify for the Bill.

   (4) It is notoriously difficult to prognosticate in many progressive conditions, particularly in organ failure and frail elderly trajectories. There could be widely different opinions about prognosis, and within the medical profession, there may be fears of legal challenges by relatives after the death of a patient if there were disagreements around prognosis. Open discussions around prognosis with patients and relatives may well be jeopardised, and threaten the highly regarded trust within the doctor-patient relationship.

The Bill as currently drafted would allow a single “registered medical practitioner” who the patient approaches for “assistance” to prognosticate. The psychiatrist has no duty regarding prognostication. There are no safeguards in place around this aspect of the Bill.

6. Requirements relating to 1st formal request
There is no mention as to how the witnesses are to be checked to ensure that they meet the current criteria. As the only potential checks being carried
about by the Procurator Fiscal Service are after death, there is scope for abuse.

There is no mention about the relatives of patients requesting “end of life assistance”. What would be the responsibilities of the patient to inform their families of their wishes? Family dynamics are often complex particularly around end of life issues.

What would be the responsibility of the “registered medical practitioner” to discuss the wishes of the patient with family members? Whilst in normal circumstances confidentiality is key to the doctor-patient relationship, when the risks to others is so severe this is breached. (E.g., contact tracing in HIV). It could be argued that the long-term consequences to a close family member of a patient undergoing “end of life assistance” without that family member’s knowledge are so severe confidentiality may need to be breached.

7. Consideration of 1st formal report

(1) (b) The manner in which patients were informed about the feasible alternatives would depend on the experience and perceptions of the “registered medical practitioner.” They may not be fully aware of what palliative care could offer, and their own opinions could unduly influence the patient. The “registered medical practitioner” should be required at least to discuss the case with other specialists involved in the patient’s care.

(3) The psychiatrist is not under any duty to look for a treatable psychiatric disorder (e.g. depression, anxiety) which may be influencing decision-making.

8. Requirements relating to second formal request
(1) (c) 15 days is insufficient waiting period to allow for any potentially therapeutic interventions to be assessed (e.g. titration of analgesia, trial of antidepressants. psychological interventions, trials of aides and appliances to improve independence etc)

10. Agreement on provision
It is unclear as to whether the patient can choose the exact time that they want “assistance”. Centres that “specialise” in this work may well become confused with hospices and palliative care services that provide end-of-life care.

12. Interpretation
“relative” does not seem to include non-legal partnerships.

Other Costs
Health Boards

A large proportion of Specialist Palliative care is provided by independent hospices, which rely on fundraising and the support of the local community to provide quality palliative and end-of-life care. The Bill confuses care with
killing, and links palliative care with assisted suicide and voluntary euthanasia. Patients who went to the hospice for a “trial period” and then despite best efforts by the hospice went on to have “assistance”, would seriously damage the reputation of the hospice, putting off patients and families who could benefit, and also damage fundraising. The Bill would damage the whole relationship of the hospice and the local community. This would impact on the delivery of Specialist Palliative Care.

The bulk of work is likely to fall on GPs and consultations around end of life issues are time-consuming, and emotionally challenging. Those GPs involved in “assistance” will likely need emotional support, which will cost time and money to the NHS.

There is no mention on what protection would be in place for minors where the patient is their parent or guardian. Insurance policies and pensions are usually void in cases of suicide, and therefore family members may sue health professionals involved in “assistance” for their “loss of inheritance”. Indemnity issues for all health professionals connected with “assistance” need to be addressed.

**NES**
As any “registered medical practitioner” can be asked to perform “assistance” the implications for training are wide.

The practice of “assistance” would need to be regulated and training would need validating.

**COPFS**
A Post-Mortem review is too late if disputes arise. It would be much better for a patient’s case to be scrutinized by a review panel prior to the killing. It is noted that the only mention of a review process is in Explanatory Notes. It is not mentioned in the Bill.

There are strong cultural, moral and legal prohibitions on killing to protect us all in society. The Bill’s absence of proper safeguards in the process of “assistance” is absolutely shocking.

Dr Angela Bentley FRCP (Edin)
Consultant in Palliative Medicine
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