End of Life Assistance (Scotland) Bill

Jane Utting

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

Assistance at the end of life is one of the roles of registered medical practitioners. Assistance to end life is not, and the proposals of the Bill would fundamentally undermine the vocation of health care professionals, whose motivation is to heal and, even where that is no longer possible, to care for living individuals, not to destroy human life.

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

(a) has been diagnosed as terminally ill and finds life intolerable; or
(b) is permanently physically incapacitated to such an extent as not to be able to live independently and finds life intolerable.

The categories of people are based on poor definitions that demand subjective judgements by medical practitioners about the quality or intolerability of another person’s life.

Diagnoses are not always correct, but can affect the way people value their lives, leading them to feel that life is intolerable. “Intolerable” – is a term that is not objective and is subject to alteration, for example by more effective intervention to deal with symptoms, or by a change in perception of the individual patient.

The Bill states that “a person is terminally ill if the person suffers from a progressive condition and if death within six months in consequence of that condition can reasonably be expected.” The process required to determine what “can reasonably be expected” is not defined in the Bill, and is open to a wide range of interpretation. If the ‘expectation’ were to be based on average results from sufficiently large samples of patients in studies conducted according to good clinical and scientific practice, a degree of rigour might be introduced. However, a fundamental point not addressed by such an argument is that medicine, while benefitting from the knowledge and understanding brought by scientific endeavour, is not about average results from a group of other people, but on the needs of the individual patient, guided by the aim of improving the condition (physical, emotional, social, spiritual) of that patient, even when curative treatment is no longer an option. The term “live independently” is not defined and the arguments about the term “intolerable” that apply to 2(a) apply here also.
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?

There is no requirement on the competence of the medical practitioner to advise on available treatments or palliative care, leading to the possibility of patients making uninformed decisions with the most severe and irrevocable consequences. Neither the time to be taken for the consultation after a “first request”, nor the method of recording the content or outcome of the consultation are specified in the Bill, which may result in inadequate consultation and discussion of alternatives to ending life.

There is no requirement for the medical practitioner to physically meet, or even discuss with the patient, either his or her second formal request, or any “agreement on the provision of assistance”. This could leave the medical practitioner totally dependent on the report of a psychiatrist to judge whether or not the patient’s perception of the intolerability of his/her life, the role of any coercion, or any other factor have changed.

The psychiatrist is expected to discuss “all feasible alternatives to proceeding under this Act”, but the level of knowledge and training required of the psychiatrist on these issues is not specified, making it difficult to ensure that the patient can make a fully informed decision – especially at the stage of a second formal request.

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

Although the possibility of coercion on the patient to end his or her life by interested parties is identified, no process is described by which a medical practitioner or psychiatrist should establish the absence of coercion.

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

No requirements on the training and professional experience of “designated practitioners and psychiatrists” are stipulated, raising serious questions about the level of competence of those who would have the power to make decisions about terminating another person’s life.

The Bill puts an obligation on medical practitioners to provide access to assistance to end life, even if they do not agree with the principle of providing such assistance. This leaves no provision for medical practitioners who believe in the intrinsic value of every human life, and cannot in conscience play a part in the ending of a person’s life.

Jane Utting
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