I write as a concerned General Practitioner in Angus re Margot MacDonald’s proposed legislation.

1) I DO NOT AGREE that a person should be able in law to request end of life assistance from a registered medical practitioner of which I am one.

This fundamentally alters the role of the doctor as an agent of healing and introduces another unwarranted and unwanted role of both arbiter and executer of a patient’s wish to end their life.

The arrogant assumption that this will fall upon the GP as an extension of their cherished professional Dr/patient relationship is a flawed concept of general medical practice and end of life care and one in which I would under no circumstances like to see operative in Scotland. This concept is open to abuse by the unscrupulous, has no justification in all historic codes of medical ethics and threatens the integrity of the doctor-patient relationship, in particular with regard to the vulnerable elderly and disabled population, whether physically or mentally.

The absence of reporting procedure and the slippage that has occurred in Holland which is notorious for Dr’s abuse of like legislation both in scope and practice are sobering facts associated with the introduction of such a bill.

The far more chilling association of the medical profession in pre-war Germany with the policy of selective euthanasia introduced by the Third Reich which led on to the full-scale and reprehensible participation of doctors in the death camps, cannot go unmentioned, distasteful as it may seem in the current context. It placed a line in the sand over which the medical profession dare not tread without risk of harming the trust their patients expect and rely on.

There is no mention in this bill of the specifics of how life will be terminated yet its main emphasis is on achieving the right conditions for this to take place. My point is that not only are GPs expected to hear and assess a patient’s request for assistance to end their life but they are also expected to carry out such requests at the end of the process which is a breath-taking assumption by the MSP.

There is no provision made for conscientious objection to this process by the doctor, the assumption that GMC guidance already covers this is likewise naive in its generalisation—there being no guidance regarding the patient’s life in licensed medical practice (the practice of abortion would appear to rely on the assumption that the fetus is not a patient!). The imposition of the patient’s autonomous wish to end their life on the physician in this case disregards the
autonomy and ethical duty of the physician to think and do differently in accordance with accepted medical practice over the centuries.

The role of palliative medicine at the end of life is an area with which I am familiar in daily practice and for which I have received further training locally. I cannot remember being asked by one of these patients to end their life but have been involved in providing symptomatic relief at the end of life for them. We are fortunate locally in having accessible high quality palliative care and advice. I know that this is not the case across the country and feel that this is more of a legislative priority than an End of Life Assistance Bill.

2) This bill makes provision for requests from 16yrs of age which is alarming in view of the vacillation and vulnerability of teenagers, whose impulsivity and wilfulness might make the maturity of such a decision questionable though there is no doubt regarding their autonomy in law.

The connection with Scotland required in this bill places unreasonable demands on Scottish GPs to cooperate with such requests if a patient has been registered with their practice for more than 18 months. They have likely been involved in the provision of care at both primary and secondary levels by this time and a Dr/patient relationship may or may not exist. If it did exist at this stage, it could not but be irrevocably altered and in my view undermined by the process of request described in this bill.

3) Intolerable or unbearable suffering are hardly objective definitions to frame legislation around which will require clinical assessment and some degree of prognostication too.

4) With regard to the consent and verification process, whilst elaborate, there are situations where the participating doctors may not agree, the knowledge or experience of GP/psychiatrist may be limited in discussing ‘feasible alternatives’ and the assessment of ‘undue influence’ is undefined as to scope or assessment.

5) Safeguards—if the patient has a change in mind re original request, how would this be ascertained and by whom?..the term ‘however informal’ is open to misinterpretation.

Thank you for consideration of these several points in opposition of this bill.

Dr Jonathan Fagerson
11 May 2010