End of Life Assistance (Scotland) Bill

R M Wardle

As a registered medical practitioner my primary duty is firstly to do no harm. My aim is to promote and sustain quality of life and to give equal weight and value to all lives. To be approached to give approval to a request for assisted death would be strongly antipathetic to my entire professional raison d'etre. This is not what I entered medicine as a profession to do and I would not wish to be associated with it. I do not agree that a person should be able in law to request end of life assistance from a registered medical practitioner.

I am very doubtful that the age of 16 is suitable for such a grave weighted request. In addition it is illogical that a person cannot vote under the age of 18 but could still make a request to die. The connection with Scotland purely consisting of registration with a medical practice is potentially tenuous and again there is a risk that the impact would be far wider than Scotland alone. As mentioned before, legal changes concerning boundaries of general practitioner registration might potentially produce arguments for wide extension of Scottish registration to English patients.

The two categories of people who would qualify to be assisted under the bill are extremely loosely defined. I am not satisfied with these and propose that they are hazardous.

Terminally ill is recognised as exceptionally difficult to define. There are many people who have an approximate prognosis of less than 6 months who subsequently survive surprisingly well, and may even make a very worthwhile recovery. There is no attempted definition of what may be found to be intolerable.

The combination of permanent physical incapacity making it impossible to live independantly and finding life intolerable is potentially extremely broad and subjective, and might include a very wide range of people with relatively minor disability. This might open up the social acceptability of requesting assisted end of life to a large number of the general population so that what is not meant to exert pressure on the individual may nevertheless become culturally acceptable or even become expected and the perceived responsible thing to do with the passage of time. The long term impact of this may considerably expand to the detriment of the frail vulnerable members of the community.

The consent and verification process proposed appears again very loosely defined. It appears that the matter is potentially left in the hand of one medical practitioner to agree to the persons request, subject to the two psychiatric reviews of capacity and absence of mental disorder. If this procedure comes in to law and practice, it does potentially impose an unwelcome burden on the medical practitioner who is anticipated primarily to be the NHS GP. Despite the optimistic forecast of incorporating it in to
ordinary general practice commitments, such consultations of weight and importance would need to be slow considerate and lengthy and require considerable reflection and communication between the parties. There is much potential for repeated consultation especially if the GP does not agree with the patients perception of suitability for the proposed criteria.

It can be assumed that there will be patients who will bring legal challenges to their GPs where there is disagreement which would make the matter even more burdensome for the medical practitioners and impact on the entire practice. In addition there is no obvious allowance in the bill for practitioners to opt out of the requirements of the bill on grounds of conscience. There will surely be many doctors who would choose not to be involved in any way. To have to carry such a final decision as to a persons suitability for end of life assistance would be almost like being on a jury for a trial for capital punishment. It would not only be irrevocable for the patient but also for the doctor who would have to live with having been part of that decision.

The definitions of the nature and type of assistance that may be used are surprisingly absent. The implications are that there are very few limits on what may be done providing it is acceptable to the parties concerned and that the doctor who has approved the death is present at the time. This seems potentially very unpleasant as one can imagine patients arguing for forms of assistance that may be quite brutal and may again draw or pressurise practitioners steadily further into far more active participation than they might choose. I note that various professional medical associations take a stern view of involvement with judicial killing in cases of death penalties imposed by a court of law, and this has potential similarities.

The proposals contained in this bill are exceptionally negative and would have far reaching consequences not only for the individuals concerned but for the Scottish and UK population as a whole. I note that cynically this is not thought to be a bill that would have major cost implications – I would contend that the costs will be discovered in legal challenges and the social negative impact that makes life more disposable.

Death, like birth, is not often simple or easy. We work hard to make births as manageable as possible for mother and child all concerned and we are also working hard at good medicine and good palliative care. It can and is being done and this should be one of the continuing goals of good general practice. It is possible to die with dignity and the minimum of distress already and this is what should be encouraged valued and upheld. Currently the majority view of the Royal College of General Practitioners is against assisted dying and I would urge you not to introduce this bill.

R M Wardle