End of Life Assistance (Scotland) Bill
Royal College of Physicians and Surgeons of Glasgow

The Royal College of Physicians and Surgeons of Glasgow is a historical establishment within the medical community. We support the professional development of Members and Fellows through postgraduate education, assessments, and higher professional examinations, thereby promoting the highest standards of care. Our membership is drawn from professionals in medicine, surgery, dental surgery, and travel medicine. We have a worldwide reputation for clinical excellence and innovation. With charitable status, the College also has wider responsibilities to society. We comment on medical aspects of public life, and seek to influence governments and public policy. We submit this response to the End of Life Assistance (Scotland) Bill Committee on the basis of these credentials.

Our response focuses on issues raised by the final question specified in the guidance for written responses, namely, ‘Do you have any other considerations on the Bill not included in answers to the above questions?’

This Bill raises complex ethical, moral and personal issues, and the College, like any other body, is not able to represent institutionally the individual views of all Members and Fellows. However we wish to express strong opposition to the principles upon which this Bill is founded, and the practicalities of its introduction to society in general, and health care in particular.

The thrust of the proposal appears to be the legalisation of the choice to summon the assistance of a doctor, or any other person who meets certain eligibility criteria, to bring about the death of an eligible requesting person. Several emotive anecdotes describing suffering and poor care are cited in the Policy Memorandum to support the proposals. It would be similarly possible to present equally emotive anecdotes in opposition to this Bill. In the UK we enjoy a high standard of health care and the College promotes this through several means. We do not dispute sound evidence of poor care, but contend that this should prompt further research and investment in palliative care provision, for instance through the Scottish Government’s initiative with Living Well, Dying Well, rather than the legalisation of assisted suicide and euthanasia.

We acknowledge that public opinion appears to favour a change in the law to allow assisted suicide or euthanasia. However we also recognise that public opinion is impressionable, and can be superficial and poorly informed. Indeed in 2005 the report from the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, (paragraphs 215 – 233) made detailed and insightful comments on public opinion, concluding that it is more reactionary than considered, cannot be accepted at face value as an authentic representation of opinion in the UK, and forms an unreliable basis for legislative change.
The proposals in this Bill are heavily dependent on the cooperation and participation of the medical profession. It is therefore surprising and disappointing that the medical profession in general, and psychiatrists in particular, have not been formally or specifically consulted in the drafting of this Bill.

The majority of doctors oppose assisted suicide and euthanasia, and opposition is particularly strong amongst those who are closely involved with care at the end of life. We consider the absence of any conscience clause to be a serious omission. Doctors do not work within a moral vacuum. In stating that ‘a doctor should not share personal views with the patient’, the Policy Memorandum misrepresents guidance by the General Medical Council, which actually prohibits the expression of personal views to patients in “ways that exploit their vulnerability or that are likely to cause them distress”. A doctor who does not believe that euthanasia or assisted suicide are right for a patient must be able to express that view, or where the patient’s decision is resolute, be excused entirely from the process. Indeed it may be professionally negligent not to dissuade patients from this course of action. The Bill would require a doctor who did not wish to participate in the procedure to refer to a compliant colleague. Since the requesting person is most likely to first approach a doctor known to him or her, the implication in such circumstances is that a doctor who does not know the patient may become involved. This is satisfactory for the majority of conventional clinical interventions, but it is wholly unsatisfactory when the decisions involve the deliberate ending of human life.

This Bill assumes that doctors will provide for euthanasia and assisted suicide, but makes no mention of training or competence. The medical profession represents a range of interest and skill, hence specialisation. Although others may consider us to have sufficient knowledge and expertise for any patient suffering from terminal or progressive degenerative diseases, this is not the case. Not all doctors will have adequate supportive or counselling skills for the level of engagement required by this Bill, the detailed knowledge of the natural history of the condition on which to base informed discussion about disease progression, treatment options, or prognosis, or the ability to adjudicate degrees of intolerability. Training would also be required to enable doctors to act with legal competence in fulfilling the requirements of this Bill.

The specific assumption that doctors have the expertise to deliberately end life is groundless. Medical care is delivered within the paradigm of competence, which in turn is dependent on training and case exposure. There is no basis in the UK for training in the deliberate ending of life, and it would take time for training programmes to be established at undergraduate and postgraduate levels. This has direct implications for UK medical schools and Royal Colleges. Given the probable low numbers of people who would wish to avail themselves of the provisions of this Bill, it is highly unlikely that any one doctor would acquire sufficient expertise to be considered competent. Significant technical problems, complications, and failure of completion are associated with euthanasia and assisted suicide, particularly in the latter. The Bill gives no account of the expectations on doctors in such circumstances. Would resuscitation of the patient, or acceleration of the assisted dying be required?
Additional clarity is required regarding the action of a doctor who is overseeing but not conducting the procedure. Highest standards are expected in every other area of medical practice, but this Bill demonstrates no concept of this in regard to its requirements.

The Bill does not provide for an independent second medical opinion, and the decision whether to offer euthanasia or assisted suicide rests entirely with the designated practitioner. The psychiatrist is required to report only on the applicant’s capacity and independence, and not with a professional opinion regarding the propriety of the procedure.

Doctors are neither qualified nor skilled in conducting the background searches which would be necessary to establish eligibility of all participating personnel. The Bill makes no mention of the need for or means of establishing the actual identity of participating personnel, this being crucially important. We are also concerned about the level of legal protection which would apply EU-wide to participating doctors, for circumstances where the requesting person is a foreign national, albeit meeting local eligibility criteria. Furthermore, whilst the law may protect a participating doctor from prosecution, it would not offer any protection against a civil suit brought against the doctor, for instance by aggrieved family members.

The Bill seems to view prognostication as a relatively straightforward but this is not the case. Prognosis will relate to the natural history of the disease, but can be influenced by disease-modifying treatment. Estimates of prognosis are notoriously inaccurate in cancer, and even more-so in non-malignant terminal conditions such as respiratory, cardiac or neurodegenerative disease. Here, and in other areas, this Bill does not contain criteria which are sufficiently robust and watertight for such a momentous outcome as the deliberate ending of human life.

Whilst the Bill would require documentation at various stages of the procedures, there is no indication about the format of such documentation. The Bill should specify what is expected, since documentation would be crucially important for legal protection of the doctor. No guidance is given regarding the requirements which would pertain to completion of death certificates or cremation papers. Whereas there would be a requirement for the death to be reported to the Procurator Fiscal, the simple expectation that due enquiry would follow is insufficient. Such enquiry should be mandatory if there is to be any meaningful scrutiny of the procedures.

The General Medical Council regulates doctors throughout the United Kingdom. This Bill would introduce complexities to this regulation because with the availability of assisted suicide or euthanasia, doctors in Scotland would be working in a different paradigm to colleagues elsewhere. There would be a fundamental difference in health care on either side of the Scottish border. Lack of prior consultation with the General Medical Council about this Bill is further evidence of how the significance and implications of this Bill have been misjudged.
The Bill anticipates that the cost of assisted dying would be less than the cost of care. It is a real concern that financial restraint may influence choices and decisions about assisted dying. We recognise that rationing does influence health care provision, but it is an altogether different thing to adjudicate the deliberate ending of human life in that context. Whilst the Bill makes scant reference to the involvement of the legal profession, it seems inevitable that legal advice will be necessary in determining various aspects of eligibility, and this is likely to involve significant cost for the applicant, thus offsetting, or more likely overtaking, any economies of the process.

We invite members of the Committee to consider the actual or potential implications of this Bill on Life Assurance policies.

In summary this Bill misjudges its implications for doctors in Scotland, and is an inappropriate response to instances of poor clinical care. For these reasons we oppose its introduction to statute.

References
1 Seale. Palliative Medicine 2009; 23: 205–212

Dr J Taylor
Honorary Secretary
RCPSSG
11 May 2010