End of Life Assistance (Scotland) Bill

SiehYean Kiew

With regards to the Call for Evidence on the End of Life Assistance (Scotland) Bill, I would like to submit my response, as detailed below in accordance with the guidelines:

1. **Do you agree a person should be able to request end of life assistance from a registered medical practitioner?**
   No. As a medical student and future doctor myself, I feel that it is unfair for a patient to make such a request of their practicing physician, thereby placing the burden of taking a life on the shoulders of one who has made a vow to act in the patient’s best interests. Even though it may be argued that the patient has absolute autonomy, and a right to choose to die should that be his/her desire, the act of taking a life runs contrary to the tenets of medicine. Throughout the years, everything we have been taught, everything we have believed in - even before entering the profession – has been to comfort, to relieve, to heal where possible; to allow patients to die with dignity – but never by actively causing death or intentionally ending life. The Hippocratic Oath states "...I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan..."

   If I may be blunt, I would like to say that I personally did not enter Medicine to kill people. I could not knowingly or intentionally take a life, even for the noblest of purposes, and I refuse to do so.

2. **Are you satisfied with the requirements for age and connection with Scotland as set out in the Bill?**
   No. 16 years seems a rather arbitrary cut-off for eligibility. Although this age is in accordance with the Age of Legal Capacity (Scotland) Act 1991, it must be borne in mind that medical capacity is dependent on several factors: the patient’s ability to understand the decision, their ability to understand the consequences and risks, the ability to understand the choices and alternatives, and the ability to remember and communicate that decision. Capacity also varies according to the magnitude of the decision, for instance, someone might have the capacity to consent to an operation to remove an ingrowing toenail, but not to consent for organ donation. For a decision of this magnitude, I think a more thorough assessment of the patient’s capacity should be required, instead of merely assuming that everyone over the age of 16 will have the capacity to make these decisions.

   Apart from that, the late teens and early twenties are not the most emotionally stable years of one’s life; it seems rather dangerous to simply use age as an eligibility requirement especially when that age encompasses a significant population known for its labile mood and impulsive decision-making. There is also some (controversial) evidence that the decision-making and executive function areas of the prefrontal and
frontal cortex in the human brain do not fully develop until the late twenties.¹

3. **Are you satisfied with the two categories of people who would qualify to be assisted under the terms of the Bill?**
   No. The terms “finds life intolerable” are repeated often in the Bill but are never defined. This is necessarily a subjective definition – who is to make that judgement? The patient? The designated medical practitioner? The psychiatrist?
   “Terminal illness” is defined as one in which death may reasonably be expected within 6 months. This sounds neat and tidy, but in actual practice is it very hard to predict with any accuracy at all how long someone might live. It is not uncommon, we have been taught (and observed during our time in the Hospices and Palliative care units) for people who were expected to die within days to continue living for weeks, and for people who were given a prognosis of several months to live on, well and healthy, for several years. People are too individual, too different in their response to disease and illness to allow any accurate prediction of prognosis using our current medical knowledge and technology.

4. **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?**
   No. The process calls for the designated medical practitioner to discuss all other alternatives with the patient, including palliative care. This places a large burden on the physician – in presenting information, how does one care for one’s patient without erring on the side of “undue influence” (if advising on the option of end-of-life assistance) or of “withholding information” (if elaborating on palliative care)?
   Also, the designated medical practitioner is defined as any medical practitioner registered with the GMC. Presumably this will most probably be the patient’s GP, however this is not stated in the Bill, raising the possibility that the patient may approach any doctor – even junior members of the medical profession who may not have the necessary experience or knowledge to deal with this situation.

5. **Do you consider the level and nature of safeguards as set out in the Bill to be appropriate?**
   No.

6. **Do you have any other considerations on the Bill not included in answers to the above questions?**
   There is no provision in the Bill for doctors to report involvement in cases of end of life assistance. This raises the question of audit, review and monitoring – a change in legislation of this magnitude, with such a great impact on medical practice should have strict protocols for reporting and monitoring, in order to ensure that this does not allow a repeat of the Harold Shipman case.
There is no mention of a conscience or “opt-out” clause, or of a referral process should the designated medical practitioner not wish to be involved in the end of life assistance.

Also, this bill has serious implications for medical training and education; it stipulates that the means of ending life be left to the physicians discretion, assuming that the medical profession are experts in these matters. In actual fact, since ending life is not part of current medical practice, I would venture to say that we are in fact inexperienced in ending life. While we might know in theory what could kill a person, there have been no formal trials to determine the best dose or medication or best method of safely and painlessly ending life. There have been reports of cases in other countries where a lethal dose was prescribed and administered, and the patient did not die. If this Bill becomes law, it means that the medical curriculum will have to be revised to include education on methods of ending life, how to do so safely and within the provision of the Bill.

There is also the issue of complications related to the process of providing end of life assistance – should the patient, choke, swallow, have a seizure - what should the attending physician do? Should he revive the patient, or hasten the death, or just stand back and not intervene? In such cases, the medico-legal issues are too complex to elaborate upon. Who takes ultimate responsibility, if things go wrong?

Should the Bill become law, it will also have implications for personal and professional support systems. It may be all very well to assume that medical staff know best how to preserve life and thus how to end life, and so should be able to do it with minimum fuss, since it is in accordance with the patient’s wishes and in a good cause. No one in the medical profession, however, can say that they have never been affected by a patient’s death while in their care; in fact, often even consultants take it hard when a patient dies while under their care. It is rather harsh (and impractical) then to assume that doctors will be able to intentionally end life, and then carry on with treating and trying to help their other patients as though nothing has happened. This Bill would mean a need for a robust support system, with time off and counseling if required. The logistics and manpower required for this when the NHS is already facing budget cuts would be near impossible in our current situation.

Miss SiehYean Kiew
11 May 2010

References: