

Assisted Suicide (Scotland) Bill

Group of Palliative Care Physicians

We are Palliative Care physicians working in Scottish hospitals and hospices. We welcome open discussion about issues relating to palliative and terminal care and wish to respond to the Assisted Suicide (Scotland) Bill by addressing questions 1,4,5,7,8 and 9 from the list presented in the call for written evidence.

Q1 Do you agree with the general purpose of the Bill to make it permissible, in the circumstances provided for, to assist another to commit suicide?

In 2010, a group of palliative care specialists convened on several occasions to discuss the End of Life Assistance (Scotland) Bill and its implications for our work. A report was submitted to the Committee rejecting the proposals of the Bill. Our response this time is broadly similar. We are opposed to the legalisation of assisted suicide as proposed in the Assisted Suicide (Scotland) Bill. This opposition in principle is articulated in more detail in our answers to the questions below.

Q4 The Bill outlines a three stage declaration and request process that would be required to be followed by an individual seeking assisted suicide. Do you have any comment on the process being proposed?

Q7 Do you have any comment on the roles of medical practitioners and pharmacists as provided for in the Bill?

We would like to answer these two questions together. Doctors would be obliged to facilitate this process of preliminary declaration and serial requests, to adjudicate the patient's assessment of their quality of life, and probably the prescription of the lethal drug whereby the suicide would be achieved. It is therefore legitimate for doctors to express their professional view on this. As for the 2010 Bill it is disappointing that the medical profession has not been explicitly consulted in the drafting of this Bill. Doctors are historically and ethically opposed to deliberate action on our part to end life prematurely. A small number of doctors (even including some palliative care doctors) do support, in principle, the concept of assisted dying in exceptional circumstances, but it is nevertheless the case that the vast majority are opposed, and this has been well attested in medical literature. Opposition amongst palliative care physicians is particularly strong and has been recorded at 94% (Seale. Palliative Medicine 2009; 23: 205-12. McCormack et al. Palliative Medicine 2011; 26: 23-33). The legalisation of assisted suicide is a societal issue and its implementation should not be dependent on doctors. Moreover, given the small number of doctors who support assisted dying and who would be prepared to be involved in the process, the dilution of any such expertise amongst eligible people nation-wide would not be sufficient to develop and maintain the high standards of care which are rightly expected in every other area of medical practice.

The principle of medical care is to promote life and health, not the deliberate hastening of death. In our specialty we recognise that the context of that principle is to alleviate symptoms, help distress, support families, and to achieve the best possible death for our patients rather than prolonging life at all costs. Much has been done to achieve the high quality of palliative care in Scotland. The availability of assisted suicide might compromise that by encouraging some people to opt for premature death rather than experience the benefits of palliative care which are

available to them and their families and which will usually help the situation.

The Committee in 2010 considered that the 28 day limit for completion of the euthanasia or suicide process could encourage a person to proceed prematurely. The present Bill has a 14 day limit which could increase that pressure.

Q5 Do you have any comment on the provisions requiring that the person seeking assisted suicide must have a terminal or life-shortening illness, or a progressive condition which is either terminal or life-shortening?

These provisions are exceptionally loose. We are closely familiar with terminal conditions where the prospects for the patient may be cautiously predicted, but the concept of a progressive condition which is, for the person, terminal or life-shortening, encompasses a wide range of common and treatable medical conditions. Whereas the legalisation of assisted suicide may have a compromising effect on our work, this additional clause could similarly compromise the work of our colleagues in many other disciplines. If this law is to be non-discriminatory, then any person with a qualifying condition would be permitted to embark on the assisted suicide process. When dealing with chronic diseases related to depression, this would place doctors in an impossible position. Does the doctor accede to a request for assisted suicide, or, conversely, apply the principles of the Scottish Government's suicide prevention strategy? For a doctor seeing patients with such conditions to facilitate their premature death would be negligent, and an abrogation of accepted professional engagement since the time of Hippocrates.

We are very much aware of the suffering facing the patients for whom we care, because we deal with that every day. Moreover we recognise that on occasions that suffering appears to be beyond what we can offer, at least medically, to alleviate it. However the availability of assisted suicide for a small group of people creates risk for the far greater number who, despite their suffering, do not want to end their lives prematurely. We support the Scottish Government's endeavours to extend high quality palliative care to people with the range of conditions implied for this Bill, for whom care is currently inadequate.

Q8 Do you have any comment on the means by which a person would be permitted to end his/her life under the Bill?

The Bill states that a person may commit suicide using a drug, substance, or other means. This would appear to sanction suicide, and its assistance by someone else, by unrestricted means. It would be extremely concerning to see that enshrined in law.

Q9 Do you have any comment on the role of licensed facilitators as provided for in the Bill?

Palliative care is a holistic approach to the care of the patient at a profound stage of life and the support of the family then and afterwards. We recognise the psychological trauma involved in this level of support and the value of working within experienced and mutually supportive multiprofessional teams. This is in sharp contrast to the role of the Licensed Facilitator whose isolated role is focussed solely on achieving the death of the patient. Whilst some people have declared their willingness to take on that responsibility, there may be some naivety as to the implications for their own health and psychological wellbeing. In addition, the

regulation of this role would be complex.

In 2010, the Committee could not recommend the general principles of the End of Life Assistance (Scotland) Bill to Parliament. We see the present Bill as broadly similar in purpose and detail, and believe that it should also be rejected.

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