

Assisted Suicide (Scotland) Bill

Strathcarron Hospice

Strathcarron Hospice provides specialist palliative care to the populations of Forth Valley, Cumbernauld and Kilsyth. Detailed below is our response to the questions posed in the consultation.

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 recent years end-of-life care has significantly developed and improved, offering holistic care that addresses, not just pain control, but other issues such as distress, overall quality of life, relationships and the meaning of life. We believe that good palliative care encourages honesty, openness and appropriate treatments that improve well-being rather than the pursuit of futile interventions. Palliative neither hastens nor prolongs death and values people until the last moments of their lives.

Crossing the boundary between acknowledging that death is inevitable and taking active steps to bring about death, changes the role of the physician, the Doctor/Patient relationship and the role of medicine in society.

Generally, it is the view of healthy people that pain must be a consequence of dying and must be unbearable. Experience of palliative care professionals is that the quality of life can be maintained, promoted and enhanced even in the face of suffering. Both individual human beings and society in general can benefit from working through meanings in the face of suffering. The ethical response to unrelieved suffering must first be to establish proper levels of palliative care before considering changing the law.

The health and well-being of a society is determined and measured by its care for people who suffer: that's what makes us civilised. Patient autonomy and choice inevitably has limits and the small number of people who wish to exercise the choice to die when they wish and seek medical assistance to do so now threaten the dignity and care of many who are even more vulnerable. Palliative care cannot flourish alongside euthanasia and, rather than enacting legislation, we need the political will to make the care of dying a priority for our society.

Q2 Do you have any views on how the provisions in this Bill compare with those from the previous End-of-life Assistance (Scotland) Bill?

The Bill still contains some very worrying provisions: in particular, we believe that the age of 16 is too young an age at which to commit legal suicide and, indeed, many situations that seem intolerable at the age of 16 are much less so when one is older.

The speed at which someone can proceed to requesting suicide to having it carried out is still of a considerable concern.

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?

The Bill should provide guidance to healthcare professionals on the standards of diligence required when assessing eligibility and consideration should also be given as to whether assessing clinicians require particular skills, expertise or knowledge beyond those universally required for medical practitioners. The Bill does not require the assessing practitioner to have any prior knowledge of the requesting person on their social and family circumstance. Assessment may be more difficult in these circumstances. Four separate practitioners may be involved in assessment and this reduces the time and continuity which tend to underpin therapeutic relationships.

In respect of the timescale, it would be possible to move through the entire process set out in the Bill in 24 days. The experience of many palliative care staff is that the views, feelings and wishes of patients change over time and may alter frequently during the course of an illness. People who have a desire for an early death or who express a wish to commit suicide often change their minds when their symptoms are addressed through appropriate palliative care. The Bill does not include a requirement that alternatives to assisted suicide are adequately explored and it seems likely that some people will commit suicide who would, otherwise, have gone on to experience a further period of life which they would have valued. The timescales in the Bill make adequate exploration of alternatives difficult. The existence of assisted suicide as an option may make it harder to engage patients in discussions about alternative options.

We believe it is important to consider whether the cooling off periods deadlines and revocation arrangements contained in the Bill could create an undesirable dynamic in which some vulnerable individuals might feel compelled to proceed.

Q5 Do you have any comment on the provision 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?

It is very difficult for Doctors to predict accurately when a person may die and the proposed legislation would make it likely that palliative care consultants would be more cautious in making such an assessment in case they implicated themselves in the suicide of a patient. At present, Doctors often complete a DS1500 form that entitles the patient to enhanced benefits if they are likely to live for less than six months. We think it is possible that palliative care consultants will be more cautious in doing so in case patients are using this as confirmation that they meet the criteria for assisted suicide.

This proposed legislation may also put pressure on a wide range of people who feel that they are a burden. There is a particular risk that disabled people will seek euthanasia as the legislation implies that their lives are less valuable and cannot be as fulfilled as those of able-bodied people.

The terminology “terminal or life-shortening and progressive condition” is not sufficiently precise and is not defined in the Bill. The Bill should also be clear about the level of expertise that it is necessary to determine whether the requesting person meets the criteria of the Bill.

Q6 Are you satisfied with the eligibility requirements as regards age, capacity and connection with Scotland as set out in the Bill?

The age of legal mental capacity to give consent should not be assumed to be the same as the age at which the individual is emotionally able to decide to end their life. Many 16 year olds have mental health problems, impulsive behaviour and self-harming behaviours.

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

We believe the Bill places a huge burden on medical practitioners who would be involved in the process of determining whether a patient met the criteria for assisted suicide. The Bill is also unclear as to who would prescribe and dispense the lethal drug. We are unclear as to whether a medical practitioner would be present at the point of suicide or where, indeed, this would or could take place. We are concerned that the option of assisted suicide would compromise the provision of good quality palliative care and people would opt very quickly for premature death without understanding the potential benefits of good quality palliative care which could, for the most part, more satisfactorily meet their needs.

We feel that the proposals will permanently change the relationship between Doctors and medical staff. This is a relationship built on trust and patients currently believe Doctors will act in their best interests and if this role encompasses any form of intentional killing the relationship will be impaired. Open discussions with patients and relatives will also be jeopardised, for example, Doctors often ask patients if they have suicidal thoughts as a way of judging their mood but with this legislation such a question would take on a very different meaning.

The current law also enables Doctors and nurses to prescribe and administer appropriate doses of analgesics and sedatives without being accused of hastening death. We think there is a real possibility that staff will become much more cautious in controlling physical symptoms in case this is misinterpreted as assisted suicide.

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

There is a possibility of medical complications arising during the assisted suicide and the legislation should take this into account and clarify whether the clinical professionals would be expected to intervene in such circumstances. It is not clear what the duty of care would be. The use of the phrase “using a drug, substance or other means” is very vague and, indeed, shocking. This would appear to sanction unrestricted means of killing someone and it would be completely inappropriate to enshrine this in law.

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

Palliative care is a holistic approach to patients and it recognises the psychological trauma this involves and the value of working in experienced and supportive multi-professional teams. It is likely that licensed facilitators will work in isolated roles and this is likely to have implications for their own health and psychological well-being. At the very end of life there could be situations where there are conflicts between family members’ belated allegations of undue influence and facilitators would need to be equipped to cope in such circumstances. Legislation should ensure robust vetting, regulation and training for facilitators.

We are unclear as to where the assisted suicide would take place and whether there would be a requirement for facilitators to attend patients’ own homes or whether there would be some form of licensed premises.

As a Hospice it is vital that the law protects us from anyone being able to insist that they can commit suicide on our premises, even without our assistance.

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