Assisted Dying for Terminally Ill Adults (Scotland) Bill

Introduction

Liam McArthur MSP is inviting healthcare professionals and members of the public to respond to his consultation on introducing a Member's Bill to enable competent adults who are terminally ill to be provided at their request with assistance to end their life. Here are links to everything you need:

- Introduction to the consultation
- The proposed bill
- **The online consultation** – for your response
- A PDF of the questionnaire (to help you think through your answers before you start)

We are particularly looking for nurses to respond to this, as the proposals specifically include references to nurses' involvement, including that nurse practitioners would be involved in delivering and preparing prescribed life-ending medications to the patient, and being present when the patient takes the medication (see page 20 of the proposed bill).

It can be a daunting prospect to respond to a Government consultation for the first time, so we hope that the following tips will help guide you through what is involved and de-mystify things a little. CMF's general guidance on responding to consultations, that can be found here, will also be helpful.

The good news is, you don't have to respond to every question, just the ones you feel most concerned about, and you can look at all the questions in advance (here) to work out what you want to say. You can also pause and save the online consultation document at any time. **And if all you have time for is to tick the relevant boxes, that is much better than nothing,** so please do that and make your voice heard.

Tips for responding to this consultation

A few general points to remember:

- Be winsome, not adversarial. This is not the place to campaign or to complain. These are not your enemies; by and large they will be well-motivated public servants gathering opinions from lots of stakeholders. If you can express appreciation for the difficult job they are doing, and be courteous and good humoured, they are more likely to take notice of what you say.
- Be measured in your language. Don't exaggerate or generalise. Where possible, cite good quality evidence, but you are not writing an article for an academic journal, so you don't need to use dozens of references. If you do quote statistics, then supply a supporting reference.
- Focus on your experiences as a nurse – have you nursed people who were asking for assistance to die because they feared the process of dying, or feared becoming a burden to loved ones, or whom you felt were deeply depressed? Information, kindness, reassurance, affirmation, and appropriate treatment of coexisting mental health disorders can give people hope and a reason to reconsider their request. Using your own experience and the stories of real people (anonymised, of course), is compelling evidence.

The consultation questions

There is an introductory series of questions about you. You are responding as an individual, a professional with relevant clinical experience. We would suggest that you tick the box saying that you are happy for your response to be published and attributed to you, unless you have good reason to think this could be problematic for you.

The first group of questions (questions 1-6 – entitled 'Aim and approach') relate to the general purpose of the consultation document. If you only have time to complete one section, this would be the best section to tackle. Here are some key areas of concern:

The bill, as it stands:

- strengthens the notion of 'a life not worth living' and undermines equality;
- coerces vulnerable people to choose death;
- undermines the nurse/patient relationship;
- fails to guarantee respect for conscience;
- holds out the lure of cutting costs; and
- does not have a sufficiently robust review policy.

You can start now if you're ready, or read on for **more detailed comment about some of these areas.**

- **The wording of the bill's aim**. 'Terminal illness' is equated to 'progressive illness.' No time limit is suggested during which the patient can reasonably be expected to die (unlike the Westminster proposals, that would restrict it to patients with a six month prognosis).

  The conditions that could qualify as 'terminal' include chronic illnesses such as diabetes and heart and lung disorders. The term could also include neurodegenerative conditions that are uncurable though not terminal, such as multiple sclerosis, muscular dystrophy and dementia. This is a very broad proposal that would include a large number of Scottish residents.

  The lack of a clearer definition of 'terminal illness' increases the likelihood that, in practice, assisted suicide will be offered to anyone with a chronic and debilitating illness who is tired of life or who, in the opinion of their clinicians, has a life 'not worth living.'

- **The nature of the nurse/patient relationship**. Nurses have a calling to care for the sick, and to 'do no harm.' In most cases nurses spend much more time with their patients than doctors do, and build a much closer, long-term relationship, so the burden of distress and moral injury is likely to be considerably heavier. How will you feel about being asked to assist a doctor in preparing a patient to receive a fatal cocktail of barbiturates? Over time, do you think nurses will just accept that 'taking life' is just part of the job?

- **Palliative care.** The availability of palliative care in Scotland is recognised as a postcode lottery. Could not resources be put into improving palliative care services, helping people to live until they die? Controlling the symptoms, rather than removing the patient? This would certainly chime with the sentiments of nurses working in the field of palliative care.

- **Safeguards**.
  i) There is no requirement for all patients who request assisted dying to be fully assessed by qualified mental health professionals. This omission is dangerous, making it likely that some whose mental health conditions are both treatable and reversible will instead receive assistance to die. The responsibility to request a full and independent mental health assessment in every case should be mandatory.

  ii) 'Pressure' and 'coercion' may not be overt or even recognised by the patient. The three main factors in someone requesting assistance to die are:
  a) a perception (usually mistaken) that they are alone in the world and that no one really cares about them;
  b) a feeling (again, usually mistaken) that they are a burden on others and that people would be better off if they were dead;
  c) fearfulness towards pain and death.

Existential angst is not a terminal illness. It may be eased by treatment with anxiolytics or antidepressants. Dignity and value are conferred by consistent care and kindness.

iii) A 14-day period of reflection seems a very short time to make what is literally a life-or-death decision. Is it long enough to ensure that a clear and settled decision has been reached?

- **Conscientious objection**
  The bill attempts to reassure those who would feel unable to participate on the grounds of sincerely held ethical beliefs. But there is no mention of statutory protection. Participation would therefore be governed by guidance from professional bodies, in this case the NMC.

- **Incremental Extension.** Almost all jurisdictions that have legalised assisted suicide and/or euthanasia have seen incremental extensions to the laws they introduced. For example, Belgium and the Netherlands are increasing the scope of qualifying persons to include **chronically ill but not imminently dying persons, those who are simply weary of life (including children) and those who lack competence to decide for themselves.** Worldwide, the picture is the same – incremental extension to the scope and scale of assisted dying.

  Note: We prefer the term 'incremental extension' to 'slippery slope' – it carries less baggage.

There are four further sections of questions, dealing with specific areas, such as financial considerations, impact on equalities, and sustainability. These sections are much shorter than the first one and there is overlap in how you might tackle them, if you are so minded. But section 1 is the main one.

There are lots of resources, facts and figures on the Our Duty of Care website if you want to research this further, or contact ethics@cmf.org.uk for more help or information.

Thank you!

Thank you so much for your help in resisting this proposed legislation. If you would like to learn more about our ethics and public policy work, and opportunities to get involved in things that matter to you, sign up for the CMF Public Policy E-News or follow @CMF_Ethics on twitter.