RCGP SCOTLAND

# Assisted Dying for Terminally Ill Adults (Scotland) Bill

**Consultation response from RCGP Scotland**

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| **About your organisation** | The Royal College of General Practitioners (RCGP) is the professional membership body for GPs in the UK. It has over 54,000 members across the UK, including over 5000 in Scotland. Our purpose is to encourage, foster and maintain the highest possible standards in general medical practice. We support GPs through all stages of their career, from medical students considering general practice, through to training, qualified years and retirement. |
| **Q1a** | Which of the following best reflects your views on the Bill? (Required)<br><br>Fully support<br>Partially support<br>Neutral/Don't know<br>Partially oppose<br>Strongly oppose<br><br>**Please provide further comments.** |

None of the options presented fully reflect the RCGP position on assisted dying. RCGP opposes a change in the law on assisted dying and therefore the Assisted Dying for Terminally Ill Adults (Scotland) Bill.

This position was ratified by the RCGP Council on 21 February 2020, following a consultation of its members. The member survey was conducted independently by Savanta ComRes and was in field between 29 October and 15 December 2019. 6,674 members from across the UK responded to the online survey, with a response rate of 13.47% of the members consulted.

Members were asked whether RCGP should change its current position of opposing a change in the law on assisted dying. The results were as follows

- 47% of respondents said that the RCGP should oppose a change in the law on assisted dying
- 40% of respondents said the RCGP should support a change in the law on assisted dying, providing there is a regulatory framework and appropriate safeguarding processes in place
- 11% of respondents said that the RCGP should have a neutral position and
- 2% of respondents abstained from answering.

RCGP Council agreed that the survey results did not support a change in the College's existing position on assisted dying. Council also decided that it will not review this position for at least five years (2025) unless there are significant developments on the issue.

In September 2023, RCGP Council approved the creation of a working group to examine what preparations the College should make for the possibility that assisted dying is legalised in one or more jurisdictions in the British Isles, to support all GPs whatever their views on assisted dying. The College position in relation to whether assisted dying should be legalised is outside the scope of the working group.

While the College is opposed to a change in law, we have made recommendations in this consultation response to represent our members' interests and concerns and ensure that protections for all patients and GPs are as strong as possible, should the Scottish Parliament pass this legislation.

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| **Q1b** | Which of the following factors are most important to you when considering the issue of assisted dying? Please rank a maximum of three options.<br><br>Impact on healthcare professionals and the doctor/patient relationship<br>Personal autonomy<br>Personal dignity<br>Reducing suffering<br>Risk of coercion of vulnerable people<br>Risk of devaluing lives of vulnerable groups<br>Sanctity of life<br>Risk of eligibility being broadened and safeguards reduced over time.<br>Other (200 characters)<br><br>**Please provide further comments.** |

The RCGP survey on assisted dying asked members to elaborate on the reasons for which they opted for their position. More information on the results of the consultation can be found on the RCGP website.[1]

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| **Q2a Eligibility**<br><br>**Eligibility – Terminal illness** | The Bill proposes that assisted dying would be available only to terminally ill adults.<br><br>The Bill defines someone as terminally ill if they 'have an advanced and progressive disease, illness or condition from which they are unable to recover and that can reasonably be expected to cause their premature death'.<br><br>An adult is defined as someone aged 16 or over. To be eligible a person would also need to have been resident in Scotland for at least 12 months and be registered with a GP practice.<br><br>**Which of the following most closely matches your opinion on the terminal illness criterion for determining eligibility for assisted dying?**<br><br>• No-one should be eligible for assisted dying<br>• Assisted dying should be available only to people who are terminally ill, and the definition of terminal illness should be narrower than in the Bill<br>• Assisted dying should be available only to people who are terminally ill, and the definition of terminal illness in the Bill is about right<br>• Assisted dying should be available only to people who are terminally ill, but the definition of terminal illness should be broader than in the Bill<br>• Assisted dying should be available to people who are terminally ill, and to people in some other categories.<br>• Other – please provide further detail<br><br>**Please provide further comments.** |

RCGP has a position of opposition to the legalisation of assisted dying (please see answer to Q1A for further details).

However, should assisted dying be legalised, it should only be available to people who are terminally ill. In practice, it should be noted that defining terminal illness is difficult, with a range of different approaches. We would not support the eligibility criteria to include provision for people who are not terminally ill but have unbearable suffering or variations thereof, such as in Canada, The Netherlands, Belgium and Luxembourg. We note however that in Quebec, Cananda, initial eligibility restrictions were successfully challenged in court and deemed to be discriminatory in their effects and unconstitutional[2].

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| **Q2b**<br><br>**Eligibility – minimum age** | **Which of the following most closely matches your opinion on the minimum age at which people should be eligible for assisted dying?**<br><br>• No-one should be eligible for assisted dying.<br>• The minimum age should be lower than 16<br>• The minimum age should be 16 |

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| | • The minimum age should be 18<br>• The minimum age should be higher than 18<br>• Other – please provide further detail<br><br>**Please provide further comments.** |
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| **Q3 – Procedure and procedural safeguards** | The Bill describes the procedure which would be in place for those wishing to have an assisted death.<br><br>It sets out various procedural safeguards, including:<br><br>• examination by two doctors<br>• test of capacity<br>• test of non-coercion<br>• two-stage process with period for reflection<br><br>**Which of the following most closely matches your opinion on the Assisted Dying procedure and the procedural safeguards set out in the Bill?**<br><br>• I do not agree with the procedure and procedural safeguards because I oppose assisted dying in principle<br>• The procedure should be strengthened to protect against abuse<br>• The procedure strikes an appropriate balance<br>• The procedure should be simplified to minimise delay and distress to those seeking an assisted death<br>• Other – please provide further detail<br><br>**Please provide further comments.** |

As stated above, the RCGP is opposed to the legalisation of assisted dying. However, in the event of assisted dying being permitted by law, RCGP is deeply concerned at the prospect of this taking place through the procedure proposed in the Assisted Dying for Terminally Ill Adults (Scotland) Bill, which assumes a central role for GPs and for general practice. RCGP does not believe that sufficient consideration has been given to the service model proposed in this Bill, either in terms of its appropriateness, or its practicalities and resourcing, and failure to properly account for these issues risks alienating healthcare professionals. Should – despite our opposition – assisted dying be legalised, RCGP would propose the Bill be significantly amended to reflect a different service model in the form of an opt-in, separate service.

RCGP does not believe that, if assisted dying is legalised, the process should be integrated into existing care pathways as part of the standard care and treatment they provide. If legalised, assisted dying should not be deemed core GP work. It is inappropriate that the Explanatory Notes for the Bill state that it is expected that the coordinating registered medical practitioner (CRMP) or registered medical practitioner (RMP) roles will "usually be the terminally ill adult's GP or primary care doctor."[3] We are similarly concerned by the assumption in the Financial Memorandum that “many of the initial discussions will take place at a regular GP appointment, albeit one which may last longer than usual allotted time.” This is a complex process, morally and

emotionally, involving considerable time for technical assessment of capacity and coercion which can be challenging. We do not believe that this work can or should be incorporated into an already very busy and stressed service, without potential detriment to patient care and significant emotional, psychological and ethical pressure on GPs.

Should assisted dying be legalised, the establishment of a separate service would ensure healthcare professionals of multiple disciplines (including GPs) who wanted to do so could still opt in to provide assisted dying, but this would be arranged through a different pathway. RCGP shares the view of the BMA that this is the most suitable approach for both doctors and for patients, and would help to ensure consistency and facilitate oversight and research.[4]

This system design would ensure that, should assisted dying be legalised, only healthcare professionals who positively choose to participate are involved in the process of assisted dying. They should also be able to choose the parts of that process to participate in. For example, a GP may opt-in to initial assessments, but not wish to participate in the prescription of life ending drugs or to provide assistance to end a patient's life. This flexibility should be accounted for in an opt-in model.

The House of Commons Health and Social Care Committee report recommends that if assisted dying were legalised in any part of the UK, the relevant governments must ensure that additional funds are made available to ensure that the service is properly resourced, and that funding and workforce are not diverted from other, already overstretched, healthcare services. This is crucial – if assisted dying is legalised, there must not be detrimental impact on our existing health and social care services for patients, including palliative care.

Furthermore, we support the BMA proposal for the establishment, should assisted dying be legalised, of an official body to provide patients with factual information about the range of options available to them. This would be an additional protection for doctors who did not wish, or did not feel confident, in providing that information, as well as ensuring that patients have access to accurate and objective information to inform their decision. In the event that assisted dying is legalised, the information this body provides should be high quality, health literacy appropriate, and available in a variety of formats including easy to read, different languages, and braille.

RCGP also agrees with the BMA proposal for the establishment of an independent and transparent system of oversight, monitoring and regulation if assisted dying were to be legalised. In addition, participating healthcare professionals would need to be provided with a comprehensive regulatory framework and guidance and undertake and maintain compulsory training in order to opt-in to deliver what is a completely new and highly complex service. This training and regulation would need to prepare healthcare professionals for and cover all elements of the provision of assisted dying, including but not limited to capacity assessment, coercion identification, mental health support, medication and prescribing decision making, and death and certification. The amount of time to train clinical staff for such new duties should not be underestimated.

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| In the event that assisted dying is legalised, RCGP would support recommendations 11 and 19 of the Health and Social Care Committee which state that training on capacity assessments is necessary, particularly in relation to vulnerable groups, as is further research on how to better provide mental health support and guidance for people living with a terminal diagnosis.[5] We should learn from international examples, and we note evidence from Dr Gary Cheung, Associate Professor and Old Age Psychiatrist at the University of Auckland, to the Health and Social Care Committee, who highlighted his recommendation that New Zealand shifts to compulsory training to improve safeguards there, based on his concern that not enough care was taken on assessing capacity.[6]<br><br>Judgements around whether the patient is being coerced are also complex and can be beyond the remit of the usual GP. Assisted dying carries with it the highest level of risk: the inappropriate death of a person. A 2022 paper 'Examining assisted suicide and euthanasia through the lens of healthcare quality' notes "There is an underacknowledged need for balancing measures or safeguards to prevent inappropriate deaths. The development of safeguards will require the examination of the impact of EAS on clinical practice, narratives and personal experiences, along with the experiences of potentially vulnerable groups including persons with disabilities, older persons and persons with mental illnesses."[7] | |
| **Q4 – Method of dying** | The Bill authorises a medical practitioner or authorised health professional to provide an eligible adult who meets certain conditions with a substance with which the adult can end their own life.<br><br>**Which of the following most closely matches your opinion on this aspect of the Bill?**<br><br>• It should remain unlawful to supply people with a substance for the purpose of ending their own life.<br>• It should become lawful to supply people with a substance for the purpose of ending their own life, as proposed in the Bill<br>• It should become lawful to supply people with a substance for the purpose of ending their own life, as proposed in the Bill, and it should also be possible for someone else to administer the substance to the adult, where the adult is unable to self-administer.<br>• Other – please provide further detail<br><br>**Please provide further comments.** |
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| **Q5 - Health professionals** | The Bill requires the direct involvement of medical practitioners and authorised health professionals in the assisted dying process. It includes a provision allowing individuals to opt out as a matter of conscience. |

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| | **Which of the following most closely matches your opinion on how the Bill may affect the medical profession? Tick all that apply.**<br><br>• Medical professionals should not be involved in assisted dying, as their duty is to preserve life, not end it.<br>• The Bill strikes an appropriate balance by requiring that there are medical practitioners involved, but also allowing those with a conscientious objection to opt out.<br>• Assisting people to have a "good death" should be recognised as a legitimate role for medical professionals<br>• Legalising assisted dying risks undermining the doctor-patient relationship<br>• Other – please provide further detail<br><br>**Please provide further comments.** |

If assisted dying is legalised, we are unambiguous that GPs and other healthcare professionals should be under no compulsion to participate in any aspect of assisted dying. While our position is opposed to a change in the law, if the Bill is passed, the legislation should be stringent in offering a genuine choice as to whether, and to what extent, any clinician might participate.

In the event that assisted dying were to be legalised, RCGP would oppose the current drafting of section 18 on conscientious objection. We would call for the Bill to be amended to provide a right to refuse to carry out activities directly related to assisted dying for any reason, without the need for this to be based on matters of conscience, or for healthcare professionals to prove the basis of that conscientious objection. Doctors should not need to prove or justify their desire not to be involved in the process. We are also aware of differing legal opinions on the competence of the Scottish Parliament legislating for conscience rights, given that regulation of medical professions is reserved to Westminster.[8]

If assisted dying were to be legalised, RCGP would support the BMA call for specific provisions in the legislation making it unlawful to discriminate against, or cause detriment to, any doctor on the basis of their decision to either participate, or not participate, in assisted dying. We would also support the inclusion of a provision for safe access zones such as those for abortion providers. Participating staff and patients must be protected from harassment and abuse.

These would be important protections; however, they do not assuage concerns about the impact on the doctor/patient relationship.

The trust embedded within the GP/patient relationship is precious and the impact assisted dying could have on this is unknown. In the system designed by the Assisted Dying for Terminally Ill Adults (Scotland) Bill which describes GPs as taking on a central role, we can foresee a multitude of circumstances in which the doctor/patient trust could be damaged. For example, conflicts could arise based on the GPs decision to participate or not, regarding the decisions they take on eligibility, at the point of care for friends and family before, during, and after the process of assisted dying, and more. GPs have a

pivotal role in Advanced Care Planning, providing palliative and end of life care for their patients and their carers and families, and trust is an important component in this.

The BMA defines moral distress as occurring when a professional is constrained in their ability to carry out what they believe to be ethically appropriate actions. Moral injury can arise where sustained moral distress leads to impaired function or longer-term psychological harm.[9] Doctors can experience moral distress in a number of circumstances, for example due to a lack of agency to make the best decisions for patients, practical experience of medical care clashing with ethical standards taught at medical school and personal ethical standards, and end-of-life care decisions.

RCGP is concerned that there are a limited number of studies on the emotional impact on participating clinicians available to inform this consultation. A 2019 review of published evidence found that participation in assisted dying can have a significant emotional impact - 30-50% of doctors described emotional burden or discomfort about participation, and 15-20% reported significant, ongoing adverse personal impact.[10] While there is a shortage of academic evidence, it is clear that many GPs, regardless of their opinion on assisted dying, have concerns about how their decision to participate, or not to participate, might impact on them, personally and professionally.

The College has existing concerns about protecting GPs from moral distress and injury, particularly after the experience of the COVID-19 pandemic, and for those working in Deep End practices serving the most deprived communities. Should assisted dying be legalised, RCGP would want to see greater mental health support and resources be made available for all doctors involved in decisions around assisted dying and end of life care. One means of achieving this would be through the Workforce Specialist Service in Scotland which provides tailored, confidential mental health support for health and social care professionals. In April 2022, doctors accounted for two thirds of all registrants with the service, and half of those were GPs. [11]

RCGP is an advocate for the role of the GP in palliative and end of life care delivery, and the majority of these services in the UK are provided by generalists. The concept of a good death goes beyond an outcome or event. Elements of a good death include holistic end of life care with the dying person being treated with dignity and respect, where people are prepared.

RCGP is committed to supporting GPs to develop practical solutions to the clinical, ethical and moral challenges that caring for patients with complex needs and frequent fluctuations in the clinical condition can present, offering clinical priority programmes in Palliative and End of Life Care, Collaborative Care and Support Planning and Mental Health. In conjunction with Marie Curie UK, we developed the Daffodil Standards for General Practice, providing a free, evidence-based framework to help practices.

There are known inequities in access to palliative care across Scotland and the UK. Hospice UK estimate that a quarter of people in Scotland aren't getting the palliative care they deserve, and long-term sustainable funding is required to underpin a whole system approach to reduce that inequity. If assisted dying is legalised, it is critical that its resourcing does not come from palliative care service funding or workforce.

We are concerned that evidence shows a lack of awareness among people who require end of life care and their families about the range of services available, and efforts should be made to improve that regardless of the legalisation of assisted dying. As described in our answer to Q3, if assisted dying were legalised, the establishment of an official body would provide patients with factual information about the range of options available to them.

This would be important to simplify and support healthcare professionals in the referral process, which may be challenging for those healthcare professionals who do not wish to participate.

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| **Q6 - Death certification** | If a person underwent an assisted death, the Bill would require their underlying terminal illness to be recorded as the cause of death on their death certificate, rather than the substance that they took to end their life.<br><br>**Which of the following most closely matches your opinion on recording the cause of death?**<br><br>• I do not support this approach because it is important that the cause of death information is recorded accurately<br>• I support this approach because this will help to avoid potential stigma associated with assisted death<br>• Other – please provide further detail<br><br>**Please provide further comments.** |

If assisted dying were to be legalised, RCGP believes that it would be important to capture both data on the immediate cause of death as self-administration of lethal medication, as well as the underlying cause, in order to ensure good data is captured for review of assisted dying and for public health monitoring.

The legal record of an individual's death may be used to settle issues of estate, insurance claims, matters of pension, etc. and it is presumed that terminology relating to assisted dying being included on this record may therefore have implications in these areas.

In current practice, Part C of the current MCCD is where the detail around the cause should incorporate information about relevant medical conditions. Part 1a involves recording the disease or condition leading directly to death, which would presumably be listed as assisted dying where this has taken place, and Part 1b would be used to indicate the underlying terminal condition which provided the eligibility for assisted dying. Current guidance for competing MCCDs is that the diagnosis must be able to be coded under the ICD-10 classification (International Statistical Classification of Diseases and Related Health Problems 10th Revision). In the clinical coding systems that are in use in electronic medical records in Scotland currently (such as ICD-10 and Read codes) there are no codes to specifically record medical assistance in dying.

If assisted dying were legalised, an approach might be for Part E of the MCCD to be changed to include a question related to assisted dying.

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| **Q7 – Reporting and review requirements** | The Bill proposes that data on first and second declarations, and cancellations, will be recorded and form part of the person's medical record.<br><br>It also proposes that Public Health Scotland should collect data on; requests for assisted dying, how many people requesting assisted dying were eligible, how many were refused and why, how many did not proceed and why, and how many assisted deaths took place.<br><br>Public Health Scotland would have to report on this anonymised data annually and a report would be laid before the Scottish Parliament.<br><br>The Scottish Government must review the operation of the legislation within five years and lay a report before the Scottish Parliament within six months of the end of the review period.<br><br>**Which of the following most closely matches your opinion on the reporting and review requirements set out in the Bill?**<br><br>• The reporting and review requirements should be extended to increase transparency<br>• The reporting and review requirements set out in the Bill are broadly appropriate<br>• The reporting and review requirements seem excessive and would place an undue burden on frontline services<br>• Other – please provide further detail<br><br>**Please provide further comments.** |

If assisted dying were legalised, RCGP believes that the reporting and review requirements should be extended. If assisted dying were legalised, it would be a major change to end-of-life care with significant cultural meaning, and the reporting and requirements should be in proportion to that significance.

RCGP would therefore recommend that, should assisted dying be legalised, the Scottish Government be required to review the operation of the legislation in a shorter period than five years. We agree with the proposal to lay a report before the Scottish Parliament within six months of the end of the review period.

While there are international examples to learn from, much is unknown about how this would unfold in Scotland. Close monitoring should be implemented to guard against unintended consequences. The Scottish Government should report on areas such as quality of patient experience, healthcare resource and workforce implications,

healthcare professionals' wellbeing, and interaction with other parts of the UK health service.

If assisted dying is legalised, RCGP recommends that data on a patient's socio-economic status be recorded, for example by using the Scottish Index of Multiple Deprivation and calculated by postcode. This would enable understanding of social patterning in the uptake of assisted dying, which will be important to monitor against instances where a person may make this choice due to a lack of other choices, influenced by poverty. Furthermore, if assisted dying were legalised, we would support the introduction of a system for routine review of all assisted death data as reported by Public Health Scotland, to ensure that the correct process was followed and to identify learning points to improve the management of cases. This is common in other countries that have already legalised assisted dying. Any system of review would need to be designed to minimise any further emotional impact on families or health professionals involved.

| **Q8** | **Do you have any other comments in relation to the Bill?** |
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RCGP has a position of opposition to the legalisation of assisted dying.

As the front door to the health service, a thriving general practice not only brings direct benefits for its patients, but also serves to protect the entire NHS. Without general practice, the rest of the health service would be overwhelmed, and the NHS simply would not exist as we know it. Today, general practice across the UK is in crisis, with a shrinking GP workforce, rising patient demand, and practices and IT infrastructure that is not fit for purpose.

In Scotland, GP numbers in Whole Time Equivalent have decreased by 3.7% since 2019. Despite the commitment from the Scottish Government to deliver 800 new GPs by 2027, the headcount has only risen by 271 in the past 6 years, and we continue to fail to retain our experienced existing GP workforce. RCGP campaigns for general practice to receive a greater share of the total NHS budget, alongside a credible workforce plan to return the GP workforce to a stable footing.

We have concerns that the model currently proposed for the legalisation of assisted dying in Scotland could have negative impacts on recruitment and retention of our healthcare workforce, and particularly of GPs, if the process proposed by this Bill is approved. RCGP is already concerned by the low level of morale in general practice. A GMC report on workplace experiences shows that GPs reported worse workplace experiences in a range of areas compared to other doctors. Over half (55%) of GPs were struggling with their workload, compared with 38% of all doctors, and GPs had the highest risk of burnout - 31% at high risk, compared with the average of 25%. [12]

This Bill seeks to introduce a brand-new element of highly complex healthcare which would require a great deal of sensitivity, time, and relationship building. There are many existing aspects of GP core work that similarly require those skills. GPs already report struggling with adequate time and headspace, and the College is profoundly

concerned that the pressures generated by the combination of rising workload and workforce shortages would be exacerbated by this Bill.

If assisted dying were legalised, it must be provided through a stand-alone service, and not as core general practice work. It demonstrates a significant underestimation of the complexity of this work that the Explanatory Notes states that 'the initial discussions will take place at a regular GP appointment, albeit one which may last longer than usual allotted time.' The 2023 RCGP survey of Scottish members found that appointment length was a key concern for members under current healthcare demands. 42% of respondents felt they did not have enough time in appointments to adequately assess and treat patients and 45% felt they did not have enough time in appointments to build the patient relationships needed to deliver quality care.

Only half of respondents agreed that they currently have enough time in appointments to ensure patient safety.

These reasons of workforce stability and resilience are part of our reasoning that if assisted dying were to be made legal, it should be delivered by an external service, with an opt-in process for healthcare professionals who wish to participate. It also demonstrates the need for close monitoring and review of the impact of its legalisation on healthcare professional wellbeing and workforce.

If assisted dying were to be legalised, there would also need to be far greater consideration of the medical legal implications with engagement from medical defence unions. Even if a healthcare professional opts-in to provide this service, the review of individual cases and fear of legal repercussion may be emotionally distressing.

Finally, as a membership body with members across the UK, RCGP recommends that there is clear communication across the different governments and jurisdictions to assess how divergence in the law on assisted dying impact other parts of the UK.

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[1] RCGP website policy page – assisted dying
[2] D. of J (2022) Government of Canada, 'Introduction - legislative background: Bill C-7: Government of Canada's legislative response to the superior court of Québec Truchon decision. Oct. 21, 2020.
[3] Assisted Dying for Terminally Ill Adults (Scotland) Bill Explanatory Notes
[4] BMA position on physician-assisted dying.
[5] UK Parliament Health and Social Care Committee report and recommendations. Assisted Dying/Assisted Suicide. 29 February 2024.
[6] UK Parliament Health and Social Care Committee report and recommendations. Assisted Dying/Assisted Suicide. 29 February 2024.
[7] Colleran, M., Doherty, A.M. Examining assisted suicide and euthanasia through the lens of healthcare quality. Ir J Med Sci 193 (2024) https://doi.org/10.1007/s11845-023-03418-2

[8] Neil, Mary. 'Protection' for conscience in the Assisted Dying for Terminally Ill Adults (Scotland) Bill - a wing and a prayer or smoke and mirrors? University of Strathclyde Glasgow.
[9] BMA report. Moral distress and moral injury: Recognising and tackling it for UK doctors. 2021.
[10] Kelly B, Handley T, Kissane D, Vamos M, Attia J. “An indelible mark” the response to participation in euthanasia and physician-assisted suicide among doctors: A review of research findings. Palliative and Supportive Care. 2020;18(1):82–8. doi:10.1017/S1478951519000518
[11] BMA blog. Vital service supporting doctors when they need it most. 2024.
[12] GMC report. The state of medical education and practice in the UK: Workplace Experiences 2023.