

Assisted Suicide (Scotland) Bill

The Royal College of Physicians of Edinburgh

1. The Royal College of Physicians of Edinburgh (RCPE) has responded to all consultations and calls for evidence on the attempts by members of the Scottish Parliament to introduce legislation on this difficult and sensitive issue. We have also offered a platform to facilitate full and frank discussion including a full day “hot topic” event in 2007 entitled “Physician assisted suicide: a good death” and, more recently, sessions within symposia on care of elderly, neurology and palliative care.
2. The following comments consider the practical implications of the legislation as proposed and what this may mean for doctors, their patients and families.

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?

3. RCPE has not taken an organisational stance on the merits of assisted suicide as it is for Fellows and Members practising in Scotland to contribute to the debate as individuals. Doctors differ in their views and any proposed legislation must provide a clear opt-out provision for doctors with an ethical, religious or other objection and this must, in turn, be clearly communicated to the public – there cannot be a presumption that most medical practitioners will support a request to end life, despite the implications of paragraph 39 of the policy memorandum. At present there is little on the face of the Bill to reassure doctors and pharmacists of their absolute right to opt out, and we strongly believe this needs to be addressed. We are keenly aware that doctors in some specialities have a particular perspective and commend the considered responses made by others with an interest care of the elderly and palliative medicine.

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

4. RCPE accepts that this new Bill addresses some but not all of the issues raised previously and, in particular, welcomes that persons contemplating suicide may require assistance but must be in a position to take the drugs themselves – this is assisting individual action and not euthanasia. However, in so doing the new draft legislation does not address the circumstances facing a small number of gravely ill and/or disabled patients seeking to end their own lives and incapable of action, thus raising the possibility of appeal under equal opportunities legislation.
5. The College also notes that the very provision of the legislation may encourage contemplation of this option by vulnerable patients. The (now more general) eligibility criteria worry some doctors and in particular those delivering palliative care. It is essential that palliative and social care support is reliably available to all in need to prevent assisted suicide becoming an option more readily taken up in some areas of Scotland or by some sections of society, simply because adequate support is not available.

The Bill precludes any criminal and civil liability for those providing assistance, providing the processes and requirements set out in the Bill have been adhered to. Do you wish to make any comment on this?

6. The explanatory notes and policy memorandum refer to a need for the medical and pharmacy regulators to amend their related guidance if this comes into law in Scotland, leaving regulated doctors in the UK with very different legal frameworks in this difficult ethical area. The College emphasises the importance of clarity to ensure doctors are not trapped between the civil and criminal law in Scotland and the professional expectations of the GMC.

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?

7. The 3 stage process offers some protection against precipitous decision taking with built in cooling off periods (albeit short), a time limit at stage 3 and the option to make wishes clear to their medical advisers and family in anticipation of a serious life limiting disease or injury. The provision to ensure that cancellation or time expiry at stages 2 or 3 do not reset the clock completely is welcome, avoiding repeat processes at an emotional time and helping to deter precipitous decisions to avoid repetition. However, these time frames do not sit easily alongside episodic confusion or depression and this underlines the importance of competent assessment of capacity and training in psychiatric conditions by doctors signing first and second statements.
8. The possible link between expressed wishes at stage 1 and a DNACPR decision if admitted to hospital requires further exploration, particularly if the patient has neglected to formally rescind a declaration that could have been made much earlier in life but is still lodged with their GP records.

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?

9. The nature of medical input at all 3 stages has changed, introducing the concept of patient defined intolerance of their circumstances. This could still leave doctors in a confrontational position with patients and/or families where they disagree and/or feel the patient is under the influence of others to his/her detriment. This adds to the risk of a gradual erosion of patient-doctor and carer-doctor relationship at a time of great need.
10. Palliative care specialists have expressed a particular perspective on how the option to seek assisted suicide influences the impact of, expectations of and demand for their services, much of which may not be well understood by the patient and his/her family at the earlier stages of the process.

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

11. The College has a concern about the lower age limit where there could be great discrepancy between the age of the trained facilitator and the requesting patient and there must be safeguards to prevent undue influence. Equally troubling would

be the prospect of 2 teenagers reaching agreement to end life in this way.

12. The removal of the requirement for a psychiatric assessment puts great pressure on the opinions of doctors assessing capacity and may result in few being prepared to take on the role or many referrals for psychiatric assessment before the doctor is prepared to sign the statement.
13. RCPE has previously expressed anxiety about the requirement to be registered with a Scottish GP for those travelling to be cared for by relatives living in Scotland. However, the College also recognises the protection against “suicide tourism” that such registration provides.

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

14. The role of the doctor in terms of making statements regarding the mental capacity and nature of condition is relatively clear (given the now very broad definition of life shortening or terminal conditions) but the judgement required as to whether the applicant’s conclusion about the quality of his/her life is consistent with his/her medical condition is much less clear and depends on individual values and perspectives and to some extent the availability of effective palliative care. It is unclear what recourse the applicant has if the doctor disagrees with his/her conclusion and whether they can immediately approach a different doctor with a first or second request for a supporting statement. This could result in extremely vulnerable patients spending their final days searching for a practitioner who shares their views.
15. It is unclear whether the patient will retain an endorsed copy of the preliminary declaration when approaching a doctor for a first statement and whether that doctor must then check with his/her GP records. It is also unclear whether the doctor asked for the second statement needs sight of the original copy of the first statement before signing the second statement and thus enabling the patient to access a licensed facilitator. The onus on the first doctor to find and send the statements to a second doctor requires some knowledge of who is willing to take on this role and it may take considerable time to find another doctor who has not opted out. There are also hard copy retention requirements on general practice for all relevant documents which will present an additional burden on GPs. This is unlikely to encourage doctors to participate and our colleagues in Primary Care will be in a better position to advise. Administration could become a burden for all.
16. The draft Bill is clear about the role of pharmacists in dispensing medication, expected to be the main (but not the sole) means of death. The policy memorandum advises that GPs would be expected to prescribe the drugs but this is not clear on the face of the Bill and neither is their ability to opt out of prescribing for a patient on their list. It should be clear that doctors have a right to refuse to prescribe and an obvious consequence of an opt-out is restricted access, particularly for those living in small or isolated communities. The 14 day deadline for the drugs to be prescribed, dispensed and administered before removal by the licenced facilitator could be a real challenge for some, especially if the preferred place of death is home in an isolated community.

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

17. See comments in para 16 above. The Bill provides some (unspecified) flexibility for non-drug methods to be applied, and the College is concerned in terms of the unpredictability of other methods and the suffering and distress that could be caused to the patient and the witnessing family or licenced facilitator as a result of a very public act and/or failed act. Doctors called to an assisted suicide could be placed in an ethically difficult position according to the manner of death or failed attempts; the opt-out provision would not extend to resuscitation responsibilities if called out by the licenced facilitator or family to a failed attempt.

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

18. There are a number of points on which the role of the licensed facilitator is unclear and which raise some important questions including the lower age limit of 16 years, namely;

- Would the training of facilitators be sufficient to confirm life extinct and ensure they know when to call the police and/or medical help after death or an unsuccessful attempt?
- Would facilitators be protected from bizarre requests for means of ending life?
- How do facilitators prevent direct involvement of close family or others excluded from the role if the patient wishes them to be part of the process?
- What would be the expectations of the facilitator if a person has a change of mind part way through the process of suicide?
- It is unclear to whom the trained facilitator must return unused controlled or prescription only medication after 14 days and any sanctions that may be applied for non-compliance.
- There must be effective quality assurance arrangements for the licensing body for facilitators.
- The prospect of a government regulated licensing authority charging for the services of a trained facilitator is troubling.

Do you have any comment on the role of the police as provided for in the Bill?

Would the police be responsible for arranging medical examiners to certify death as for other deaths reported to them, or would this fall to the licensed facilitator – see para 18 above?

Do you have any comment to make about the Bill not already covered in your answers to the questions above?

19. Cancellation arrangements may be difficult to enact where patients have made

preliminary declarations many years earlier and have moved away from their original GP.

20. The tracking and transfer arrangements for hard copy documents when other records are electronic seems fragile. It is unclear what the position would be if a second complete set of documents was started by a patient without cancelling the originals.
21. The costs anticipated for introducing such a system potentially underestimates the training costs for all concerned and the number of registration applications and therefore the burden of record keeping on GPs.
22. It is far from clear that the assumption is correct that one of the two required doctors prepared to sign supporting statements will be the applicant's own GP or consultant.

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