Consultation on Liam McArthur MSP's

Assisted Dying for Terminally Ill Adults (Scotland) Bill

Response from Royal College of Physicians of Edinburgh

The Royal College of Physicians of Edinburgh ("the College") is a professional membership organisation that sets clinical standards and aims to improve the quality of patient care. Founded in 1681, we support and educate doctors in the hospital sector throughout the UK and around the world with over 14,000 Fellows and Members in over 90 countries, covering 54 medical specialties and interests. The College enables a worldwide community of physicians and their teams to advance the health of our global population for the long-term benefit of society acting as the voice of our membership, engaging in health policy and promoting equality and human rights.

The College's Fellows and Members work in a diverse range of medical specialties and hold a wide range of personal and professional opinions on the issue of assisted dying. The College has responded previously to related consultations on assisted dying and has participated in public and professional engagement activities (including "hot topic" events) to stimulate informed debate on this very challenging subject. College views have also been influenced by the perspective of members of our Lay Advisory Committee and Fellows with expertise in medical ethics.

The College continues to take a position of having no organisational stance on assisted dying, most recently confirmed by a decision of College Council on 17 September 2021. We recognise that our Fellows and Members have their own perspectives on this very complex topic and that it will be for the Scottish Parliament to determine the fate of this proposed Bill, informed by public opinion and expert views.

Doctors have a professional responsibility to protect the interests and respect the wishes of their patients; it is in this spirit that the College identifies issues requiring greater clarity and identifies expected practical difficulties regarding the current proposals as we understand them.

Aim and approach

1. Which of the following best expresses your view of the proposed Bill?

~~Fully supportive~~
~~Partially supportive~~
~~Neutral (neither support nor oppose)~~
~~Partially opposed~~
~~Fully opposed~~
Unsure

Please explain the reasons for your response.

None of the above. The College has no organisational stance on assisted dying.

Fellows with expertise in medical ethics have stated that there appears to be a presumption in the Consultation document that the opinion of certain moral philosophers is authoritative. Moral philosophers do not hold a privileged stance in this debate. Further, there are philosophers on either side of the discussion.

Footnote 1 in the Consultation document (p.3) claims that the notion of suicide does not apply to terminally ill people because "the choice to live has already been taken away." This is a contentious suggestion and appears to attempt to avoid the negative and emotive connotations of the term 'suicide'. There are grey areas with respect to what does and does not constitute suicide, and while there are debates over the meaning of these concepts, the act of unambiguous voluntary self-administration of a lethal drug with one's own rational intention of taking one's own life is incontrovertibly an act of suicide, regardless of the circumstances. Further discussion on the terminology in this debate can be found in the BMJ[1]. The College's use of the term "assisted dying" throughout this response relates to the fact that this is the term used in the consultation document.

The College is concerned that there is not necessarily detailed understanding in wider society of what assisted dying legislation would actually mean. In 2017, a New Zealand survey[2] found that 66% of those polled thought assisted dying includes turning off life support, 51% thought it includes stopping medical treatment, and 59% thought it includes do not attempt cardiopulmonary resuscitation (DNACPR) requests.

2. Do you think legislation is required, or are there are other ways in which the Bill's aims could be achieved more effectively? Please explain the reasons for your response.

The UK Supreme Court has already clarified that legislation would be required to introduce assisted dying[3].

As the aim of the proposed Bill is "to enable mentally competent adults who are terminally ill to be provided with assistance to end their life at their request", the College does not see that there would be another way to achieve this.

3. Which of the following best expresses your view of the proposed process for assisted dying as set out at section 3.1 (Step 1 - Declaration, Step 2 - Reflection period, Step 3 - Prescribing/delivering)?

~~Fully supportive~~
~~Partially supportive~~
~~Neutral (neither support nor oppose)~~
Partially opposed

[1] *Definitions under dispute* https://www.bmj.com/assisted-dying
[2] https://euthanasiadebate.org.nz/wp-content/uploads/2018/06/Euthanasia-Poll-Results-November-2017.pdf
[3] See R (on the application of Nicklinson and another) (Appellants) v Ministry of Justice (Respondent) 2014, at para.314. (https://www.supremecourt.uk/cases/docs/uksc-2013-0235-judgment.pdf.)

~~Fully opposed~~
~~Unsure~~

Please explain the reasons for your response, including if you think there should be any additional measures, or if any of the existing proposed measures should be removed.

Fellows have identified that the main issue in the process is eligibility for assisted dying as laid out in the document. It is very wide. This definition and guidance for doctors to identify such patients was developed for another purpose: to improve equitable eligibility to benefits for patients with all conditions and for them earlier in the illness trajectory through the Social Security (Scotland) Act 2018. The intention behind this definition was not to identify patients for assisted dying. For the purposes of providing social security, a person is terminally ill if they are deemed by doctors as 'unable to recover', regardless of the time they have left to live. The College suggests that in these circumstances, the proposed Bill should make reference to the CMO's more specific guidance around the BASRiS eligibility guidance.[4]

Providing informed consent about realistic alternatives to assisted dying is also a role that requires excellent communication skills and significant experience and competence in all areas of generalist and specialist palliative care and is unlikely to be fulfilled by any single doctor. The College would suggest that a multidisciplinary team assessment and exploration of options and choices would be a more realistic suggestion for this stage of the process so that all physical and psychosocial needs can be assessed.

The reflection period is difficult to generalise as each individual situation would require a person centred approach, with rigorous safeguards.

4. Which of the following best expresses your views of the safeguards proposed in section 1.1 of the consultation document?

~~Fully supportive~~
~~Partially supportive~~
~~Neutral (neither support nor oppose)~~
Partially opposed
~~Fully opposed~~
~~Unsure~~

Please explain the reasons for your response.

The proposed Bill mentions that the doctor would be responsible for ensuring that no coercion was taking place, but contains no robust method of assessing this or indeed for identifying the extent to which the fear of being a burden is contributing to the request for assisted dying.

[4] Chief Medical Officer's guidance for clinicians completing a BASRiS form. Scottish Government (2021) https://www.socialsecurity.gov.scot/guidance-resources/guidance/chief-medical-officers-guidance-for-clinicians-completing-a-basris-form-for-terminal-illness

The College wishes to raise concerns about the undue legal, clinical and personal responsibility this would place on its Fellows and Members. The College also wishes to raise a question about the extent to which competence would be assessed and evidenced for the ability to provide informed consent regarding the availability 'of palliative, hospice, and other care options'. Current awareness of the nature and provision of generalist and specialist palliative care is well evidenced to be highly variable amongst clinicians.

5. Which of the following best expresses your view of a body being responsible for reporting and collecting data?

Fully supportive
~~Partially supportive~~
~~Neutral (neither support nor oppose)~~
~~Partially opposed~~
~~Fully opposed~~
~~Unsure~~

Please explain the reasons for your response, including whether you think this should be a new or existing body (and if so, which body) and what data you think should be collected.

An independent regulatory body with robust reporting requirements would be essential. The College is concerned about any new clinical policy implemented without a robust clinical evidence base. All other areas with legislation for assisted dying report data after the death and this data is provided by the prescribing doctor. In the post-Shipman era in the UK, this approach is unacceptable and the College would recommend that a regulatory body would require independent oversight and governance of all stages of the process from eligibility assessment to capacity assessment to medication decisions and prescribing to death and certification. The College would strongly suggest that physicians should not be required to omit the true cause of death as is suggested on the proposed Bill. Cause of death should be entered as self-administration of lethal medication, to allow adequate scrutiny by the Medical certification of cause of death (MCCD).

6. Please provide comment on how a conscientious objection (or other avenue to ensure voluntary participation by healthcare professionals) might best be facilitated.

College Fellows have suggested that in general for this proposal, a process could be considered which sat entirely with the court system and was outside of mainstream healthcare and would require doctors to opt in rather than opt out. Courts are well established to be able to make judgments on issues such as assessment of quality of life and/or unbearable suffering, and ensure robust transparency in the decision-making process.

If this was not feasible, conscientious objection could be addressed through the processes outlined in the GMC guidance on *Personal beliefs and medical practice*[5].

Financial implications

7. Taking into account all those likely to be affected (including public sector bodies, businesses and individuals etc), is the proposed Bill likely to lead to:

- a significant increase in costs
- some increase in costs
- no overall change in costs
- some reduction in costs
- a significant reduction in costs
- don't know

Please indicate where you would expect the impact identified to fall (including public sector bodies, businesses and individuals etc). You may also wish to suggest ways in which the aims of the Bill could be delivered more cost-effectively.

Equalities

8. What overall impact is the proposed Bill likely to have on equality, taking account of the following protected characteristics (under the Equality Act 2010): age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation?

~~Positive~~

~~Slightly positive~~

~~Neutral (neither positive nor negative)~~

~~Slightly negative~~

~~Negative~~

Unsure

Please explain the reasons for your response. Where any negative impacts are identified, you may also wish to suggest ways in which these could be minimised or avoided.

There are likely to be a variety of impacts. Some adults who meet the eligibility requirements and wish to have an assisted death could be prevented from doing so if the method is limited to swallowing a lethal prescription. There are circumstances in which patients with cancer or neurological conditions are unable to swallow medication, for example, oesophageal cancer or external compression of the oesophagus by enlarged nodes. Other patients may not be able to raise

[5] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice/personal-beliefs-and-medical-practice

their arm to their mouth in order to consume the lethal medication. This would need to be taken into consideration so not to discriminate against these groups of people.

There may be geographical inequalities as those patients who may wish to request an assisted death in small and isolated remote and rural communities may have difficulty finding a medical professional who does not object on ethical or faith based grounds to the principle. Conversely, potentially a patient in future would not have to incur the expense, and subject themselves to the discomfort, of travelling abroad to seek an assisted death.

Sustainability

9. In terms of assessing the proposed Bill's potential impact on sustainable development, you may wish to consider how it relates to the following principles:

• living within environmental limits

• ensuring a strong, healthy and just society

• achieving a sustainable economy

• promoting effective, participative systems of governance

• ensuring policy is developed on the basis of strong scientific evidence.

With these principles in mind, do you consider that the Bill can be delivered sustainably?

~~Yes~~
~~No~~
Unsure

Please explain the reasons for your response.

The College is concerned that there are current inequities in access to generalist and specialist palliative care across Scotland. The conversations around realistic anticipatory planning are complex, challenging and perceived as requiring more time than health and social care professionals have to offer. Evidence shows that growth in palliative care services stalled in Belgium and the Netherlands, where assisted dying is legal, from 2012, despite continuing to develop in non-assisted dying countries.[6]

A key reason stated for the need for assisted dying is the fear of poor pain control or terrible suffering at the end of life. Sustainable funding and support to improve awareness and access for all health and social care staff to the Scottish Palliative Care Guidelines[7] and also to evidenced and available resources such as the Safer Prescribing Opioids Tool App[8] would markedly improve the confidence and safety of using opioids appropriately to improve pain control. This would in turn

[6] Arias-Casais N *et al*, Trends analysis of specialized palliative care services in 51 countries of the WHO European region in the last 14 years. *Palliative Medicine*, 2020; **34**(8): 1044-56.
[7] Scottish Palliative Care Guidelines - Home
[8] https://rightdecision.scot.nhs.uk/spot-safer-prescribing-of-opiooids-tool/

reduce the impact of symptoms such as delirium at the end of life and improve the ability to manage any distress.

The College would like to see the issue of how complications and drug reactions at the time of attempted death would be addressed. There is also the issue of what role an attending doctor would be expected to take if the attempted death failed or was clearly causing distress. The College would want to ensure its Fellows and Members were protected from having to intervene to administer a lethal injection in this situation but equally there would be a clinical duty to alleviate distress and so the implications of this need to be considered and explicitly addressed within any proposal.

The Consultation document contains a section on "Consequences of the current position" (2.2, p.9–11), but there is no consideration of the unintended and potentially adverse consequences of the proposed legislation. Dutch official guidance acknowledges that "assisted suicide" (their term) can fail[9].

10. Do you have any other additional comments or suggestions on the proposed Bill (which have not already been covered in any of your responses to earlier questions)?

The College notes that a consultation was recently held on a proposed National Care Service and it seems logical to have further information on these proposals, when enhanced provision of high quality social care may influence the views of some patients regarding assisted dying.

The College would wish any proposed Bill to detail how it would ensure and sustain increased levels of resource for generalist and specialist palliative care and for robust and person centred social care provision. It is our responsibility as a caring and compassionate society to ensure that a request for an assisted death would not be made on the basis of lack of access to good end of life health and social care.

The College would like to highlight that there is no robust evidence base to inform any clinical practice regarding the prescription of lethal oral medication. The proposed Bill would require a doctor to issue a prescription for a patient with no evidence based guidelines to support the prescribing choices. Oregon uses cocktails of up to 5 drugs and is on the 4th protocol in seven years (see Oregon 2020 DWDA report). The report acknowledges that such mixtures have resulted in more prolonged deaths.

The College is very concerned to note the speed with which Canada has moved from legislation similar to the proposed Assisted Dying Bill to legislation which allows euthanasia by lethal injection for individuals irrespective of capacity and irrespective of terminal illness. We would be seeking assurance and stringent safeguards against that situation occurring in Scotland.

[9] https://www.government.nl/topics/euthanasia/euthanasia-assisted-suicide-and-non-resuscitation-on-request