Assisted Dying for Terminally Ill Adults (Scotland) Bill

Health, Sport and Social Care Committee Call for Evidence

Response from the Royal College of Psychiatrists in Scotland

The Royal College Psychiatrists in Scotland (RCPsychiS) is the primary body representing the profession of psychiatry in Scotland. We are pleased to submit this response to the Assisted Dying for Adults with Terminal Illness (Scotland) Bill. If the Health, Social Care and Sport Committee considering the Bill would find it helpful, we are willing to provide oral evidence on the issues raised in this response.

Consultation and Survey

Throughout 2023/2024 there has been sustained discussion about the Bill and its implications for psychiatry via academic meetings, forums and conferences across the College in Scotland. Discussions at these events, and afterwards, have informed our collective response.

In order to gauge the views of the profession as widely as possible, RCPsychiS undertook a survey of its membership in April and May 2024. It was not the intention of the survey to establish whether the College in Scotland is in favour or opposed to the principle of assisted dying for terminally ill adults; we asked a range of questions, with a primary focus on the roles proposed for psychiatry in this Bill. We also considered the profession's concerns about possible consequences not specified in the Bill.

Centrally, at present, RCPsych does not have a formal position on assisted dying.

The survey questions and the headline figures of the results are attached as appendix 1 and appendix 2 respectively. There were, in addition, many free text answers which we have analysed to further inform this submission.

We have divided the submission into 17 sections. Where possible, we have summarised our position and made associated recommendations under each heading.

1. Title of Bill and name of practice

The Bill is titled Assisted Dying. Other terms are used in other jurisdictions. One such is Assisted Suicide. Arguments have been made in favour of, or opposition to, each term. Assisted Suicide is a more accurate description of the practice proposed in the Bill, but is felt by some to be pejorative and stigmatising. Assisted Dying can be interpreted widely to encompass on the one hand euthanasia (the active administration of drugs by medical professionals with the intended result of death, which is not provided for in the Bill), and on the other hand the entire practice of palliative care (i.e. care intended to relieve the symptom burden of those who are dying, but not to bring about their premature death).

There is no consensus within RCPsychiS about a preferred single term for the practice proposed. While the alternative portmanteau term Assisted Dying/Assisted Suicide may be inelegant, it does not discount one set of arguments about the best description of the practice.

Conclusion:

There is concern within RCPsychiS that the exclusive use of the term Assisted Dying in the Bill is misleading, in that it represents only one set of views about appropriate terminology and is too broad.

Recommendation:

The term Assisted Dying/Assisted Suicide (henceforward abbreviated AD/AS in this document) should be used instead.

2. General views regarding AD/AS amongst psychiatrists

The profession in Scotland is clearly split as to whether AD/AS should be legalised for eligible adults with terminal illness as defined by the bill, with the survey showing that 41% of respondents were broadly or strongly opposed, 45% broadly or strongly in favour, and 14% undecided. Respondents made many strongly voiced arguments both in favour of and in opposition to the Bill.

Conclusion:

There is no overall consensus within RCPsychiS about whether AD/AS should or should not be legalised.

Recommendation:

RCPsychiS makes no general recommendation in favour of or in opposition to the Bill. The rest of this submission relates to specific concerns regarding the roles proposed for psychiatry within this Bill (and possible future Bills).

3. Definition of terminal illness

The bill proposes that AD/AS should only be available for people with terminal illness, defined as:

"…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."

[Section 2]

This is a very wide definition. Several of its terms are unhelpfully vague for such a crucial role in proposed legislation. It developed from a similar definition introduced to ensure timely access to financial benefits for people with serious illness. Its adoption within this Bill is an application of that definition to a purpose for which it was not intended, thereby undermining its validity. It is also inconsistent with definitions used in other jurisdictions, raising questions about the reasons for the choice of this definition, and the evidence on which that choice has been based. Terminal illness is not defined in the Bill by anticipated life expectancy, and there is no requirement patients should experience intolerable suffering to become eligible for AD/AS.

This definition would exclude from eligibility people with mental, but not physical, illnesses, except (probably) those with conditions which are both mental and physical in nature, such as dementia, and (possibly) those with illnesses which, while mental in nature, lead to severe physical consequences (such as anorexia nervosa).

Conclusion:

The definition of terminal illness adopted within the Bill is problematic. There is no consensus within RCPsychiS on a preferred alternative definition, and we do not recommend one. However, we do wish to draw attention to problems flowing from the adoption of this definition, insofar as they relate to psychiatry.

3.1 Eligibility of people with dementia

While the term “progressive” is not defined in the Bill, there is no doubt that dementia would fit this criterion under any reasonable definition. It is also clear that dementia is a condition from which recovery is impossible, and which can reasonably be expected to cause premature death.

However, the term “advanced” is also undefined. While many people with advanced dementia will have cognitive impairment of a degree sufficient to impair or remove their decision-making capacity to request AD/AS, this is not necessarily or universally true. It is therefore possible, indeed likely, that there will be people who retain decision-making capacity despite a clear diagnosis of dementia which may well be considered advanced, particularly given the Bill’s lack of definition of this term. It is unclear if the Bill’s intention is to include dementia as an eligible condition by leaving the term undefined. Clarity on this point would be helpful.

Diagnosing dementia is not always straightforward, especially in the early stages. A proportion of initial diagnoses are subsequently revised, and new diagnoses made which would not fit the definition of terminal illness the Bill adopts. For example, it is well established that some people thought to have dementia are subsequently found to have depressive pseudo-dementia, which resolves with successful treatment. The best known such case is that of Ernest Saunders, one of the Guinness Four, who was sentenced to five years in prison for fraud in 1990. Early in his sentence he was misdiagnosed with Alzheimer’s dementia and released on health grounds. He was subsequently treated for depression and recovered. He is still alive. In his case, misdiagnosis led to early release from prison followed by recovery. In someone seeking AD/AS, comparable misdiagnosis would lead to eligibility for AD/AS with the potential for death.

This is a manifestation within psychiatry of the wider problem of diagnostic revision, whereby illnesses which would make a patient eligible for AD/AS are subsequently re-diagnosed as different conditions which would not be so eligible, and which then remit after appropriate treatment.

In discussion and free text responses to our survey, a majority of members in Scotland supported the inclusion of dementia as an eligible condition, provided capacity was retained up to the point of death. A small number argued that it should be possible to access AD/AS for dementia via an advanced directive, which is excluded by the current Bill. Other respondents raised the concern that if considered eligible, those with dementia might request AD/AS earlier than they would otherwise wish, for fear of losing capacity before accessing the intervention. Concern was also expressed that people with dementia may

request AD/AS out of fear of becoming a burden to relatives, financially or otherwise, especially if they have insufficient support from health and social services in managing the consequences of their dementia.

Requests for assessment by psychiatrists of those with dementia would naturally fall mainly to those working in Old Age Psychiatry. Our survey showed that 52% of the respondents from the Faculty of Old Age Psychiatry in Scotland were broadly or strongly opposed to legalising AD/AS, and 30% broadly or strongly in favour. 63% indicated they would opt out of participation in any such role.

Conclusions:

1. It seems likely that a proportion of people with dementia would be considered potentially eligible for AD/AS provided capacity is retained, but this is unclear because of the lack of definition of the term “advanced”.

2. Marginalised, dependent, or insufficiently supported people with dementia may request assisted AD/AS, not because they wish to die but for other reasons.

3. A clear majority of the sub-speciality of psychiatry in Scotland dealing with dementia have declared their intention to opt out of participation.

4. Diagnosing dementia, especially in its early stages, can be complex, time-consuming and riven with a degree of uncertainty which only resolves with the passage of time, and not always then. Ending the life of a patient misdiagnosed with such a condition removes this chance of recovery.

Recommendations:

1. RCPsychiS recommends that the Bill be amended to add clarity as to whether those with dementia and retained capacity would be eligible for AD/AS.
2. National decision makers tasked with implementing the Bill (if enacted) need to be aware that a clear majority of the relevant specialist psychiatrists working in this area in Scotland have declared an intention to opt out of participation. Services will need to be configured in recognition of this.

3.2 Eligibility of people with anorexia nervosa

Anorexia nervosa is a mental illness which, when severe, carries high rates of death through the physical consequences of starvation. It also has the highest rate of death by (unassisted) suicide of any mental disorder. Death by either of these routes is not inevitable, and in this sense the condition is not progressive and therefore not akin to dementia or terminal cancer. It is inaccurate to describe anorexia as a condition from which people are “unable to recover,” even if it might “reasonably be expected to cause their premature death.”

In clinical practice in the field of eating disorder, the term “advanced “is not normally used, as it implies incorrectly that the condition must be progressive, tending only in one direction. Instead, it would be described as “severe”.

Discussion and a small number of free text responses argued that for these reasons anorexia nervosa should not be considered a condition eligible for AD/AS. No respondents argued the contrary position. Some made the point that, at present, severe anorexia can be

treated under the Mental Health (Care and Treatment) (Scotland) Act (MHA), even when patients say they would rather be dead than gain weight. Allowing anorexia nervosa as a condition eligible for AD/AS would radically alter current standard practice in this area, in a way potentially detrimental to the majority of sufferers.

Conclusion:

RCPsychiS takes the view that anorexia nervosa is not an eligible condition, as it does not meet the definition of terminal illness in the Bill. Taking a contrary view will call into question current standard practice in the management under the MHA of those with severe anorexia.

Recommendation:

RCPsychiS recommends that either the Bill itself, or the associated explanatory notes, are amended to clarify that anorexia nervosa, no matter how severe, is not a terminal illness under the definition used in the Bill.

3.3 Eligibility of those with other mental illnesses

Schizophrenia, schizoaffective disorder, bipolar disorder and other chronic psychotic conditions constitute a group collectively termed severe and enduring mental illness. People with these diagnoses suffer much increased long-term mortality and morbidity, as well as reduced life expectancy. It is therefore arguable that they fall under the "reasonable expectation of premature death" element in the Bill's definition of terminal illness. However, these conditions, while severe, are not progressive in the sense understood in the Bill, and the final outcome in terms of premature death is not an inevitable consequence of developing the original disorder, even if made more likely by it. It is also not true to say that these are conditions from which people are unable to recover.

Conclusion:

RCPsychiS considers that severe and enduring mental illnesses are not conditions for which patients are eligible for AD/AS under the definition in the Bill.

Recommendation:

RCPsychiS recommends that the Bill and/or its associated explanatory notes are amended to make this clear.

4. Exclusion of those with co-morbid mental disorder

The first page of the Bill includes the following provision, under Section 3 on Eligibility:

"(2) A person has capacity to request lawfully provided assistance if they—
(a) are not suffering from any mental disorder which might affect the making of the request…"

As worded, this entails the exclusion from eligibility for AD/AS of anyone who would otherwise be eligible, but who suffers a comorbid mental disorder in addition to a qualifying terminal physical illness. Consequently, and for illustrative purposes, a person with terminal lung cancer and depression would not be eligible for AD/AS even if their depression does

not influence their decision to seek assisted dying. Any mental disorder, whether mental illness, learning disability, autism or personality disorder, “might” affect the making of the request. Given what is known about the prevalence of mental disorder, especially depression, in the terminally ill, this means the majority of cases are likely to be excluded on this criterion. Large numbers of survey respondents argued forcefully that this criterion is discriminatory and stigmatising. None argued in favour of it.

The model of capacity on which the Bill relies is clearly based heavily on the model of (in)capacity elaborated in the Adults with Incapacity (Scotland) Act 2000 (AWI), albeit with the inversion from incapacity to capacity, and the related reversal of the presumption that all adults have capacity for all decision until proven otherwise. However, this is not the only way to approach the subject of (in)capacity and future incapacity legislation may treat it differently, such as via the concept of autonomous decision making.

Section (3) (4) of the Bill specifies that the definition of “mental disorder” in this context is that set out in the MHA. This definition may well be subject to change, for example via future legislation introduced by the Scottish Parliament in its response to the recent Scott Review of the current MHA. There are also proposals under active consideration to remove autism and learning disability from the category of “mental disorder” for MHA purposes. This raises the dilemma that under the Bill, anyone with a learning disability or autism could not access assistance in dying if these conditions are considered mental disorders; while if they are not considered mental disorders, they could not be held to impair capacity to request assisted dying even if it is clear that they do.

This Bill’s reliance on other legislation for relevant definitions fails to recognise that these definitions may change, or indeed that proposals for revised definitions are currently under active consideration. It is therefore possible that the definitions adopted in the present Bill may be outdated even before the Bill comes into force.

Either way, the presence of conditions such as autism and learning disability, and the degree to which they affect capacity, needs to be confirmed by relevant specialists. These diagnoses are not always straightforward, and determining the degree to which they do or do not impair decision-making capacity can be complex, requiring time, multi-professional assessment and team discussion. Even then there can be residual uncertainty and therefore potential for disagreement.

The Bill and its explanatory documents say nothing about how the presence or absence of mental disorder which might affect the making of the request is to be assessed, raising questions such as: by whom? How? At what stage? With what effect?

Conclusions:

1. There is a strong consensus among RCPsychiS members that this section, as worded, is discriminatory against people with mental disorder alongside a qualifying physical illness.
2. The Bill fails to recognise that the concept of incapacity and the definition of mental disorder adopted within it are subject to change, potentially rendering the Bill outdated on enactment, and therefore unworkable.
3. The absence of detail about how assessments of mental disorder are made is a defect of the Bill.

Recommendations:

1. RCPsychiS recommends a rewording of this section of the Bill, replacing “might affect the making of the request” with “affects the making of the request.”
2. The Bill should be amended to ensure definitional consistency across different legislative instruments, now and in the future.
3. There is a need for much greater clarity within the Bill and associated documents about the assessment of co-morbid mental disorder.

5. Further assessment of capacity

Section 7 of the Bill provides that a registered medical practitioner (RMP) carrying out an assessment under Section 6

“…may, if they have doubt as to the capacity of the person being assessed to request lawfully provided assistance to end their own life, refer the person for assessment by a registered medical practitioner who is registered in the specialism of psychiatry in the Specialist Register kept by the General Medical Council or who otherwise holds qualifications or has experience in the assessment of capacity.”

Section 7 further provides that the RMP must “take account of” any opinion so provided.

Many RCPsychiS members responded on the question of capacity, making the following points:

1. Assessing decision-making capacity is a core skill expected of all doctors with regard to decisions falling within their own areas of practice. It is not a specialist skill reserved to psychiatrists or psychologists across all areas of practice.
2. Practitioners other than doctors can have valuable roles in assessing capacity. They include psychologists, nurse specialists, speech and language therapists, occupational therapists and others. As currently worded, the Bill excludes these practitioners from roles in assessment of capacity to request AD/AS.
3. Assessing capacity can be difficult in marginal cases, with much room for uncertainty, doubt and disagreement. In other areas of practice, multidisciplinary team meetings are necessary to incorporate assessments by other practitioners (see above) and arrive at a fully informed view.
4. The AWI makes clear the default position, namely that it is presumed that all adults have capacity for all decisions which fall to them, until incapacity has been proven by a relevant professional. The burden of proof falls on that professional, and is to be decided on the balance of probabilities. When assessments of these questions fall to psychiatrists, it is normally because there is evidence that the person concerned has a definite or possible mental disorder. This Bill reverses that presumption, requiring RMPs, possibly assisted by psychiatrists, to confirm capacity in all cases, even when there is no evidence at all of mental disorder.
5. Where there is evidence of definite or possible mental disorder which calls capacity into question and the assessing clinician is uncertain or unable to determine capacity, then a psychiatrist may be able to provide additional specialist expertise. Capacity for treatment for physical disorder requires significant involvement of the clinician determining the medical treatment. Any psychiatric assessment should be undertaken

in conjunction with this. This work is part of the core business of psychiatry, at least for patients in current psychiatric care, and is resourced as such.

6. Psychiatrists do not have expertise beyond that of other doctors where there is no such evidence. Because it is clear such work is not part of the core business of psychiatry, it is not resourced accordingly.
7. In this context, the best placed doctor to assess capacity to request AD/AS is either the relevant specialist for the underlying terminal illness e.g. an oncologist or palliative care consultant, or a GP with prior knowledge of the patient.
8. It is not clear what is meant by the requirement that a RMP must "take account of" the conclusion of a psychiatric assessment. If the RMP disagrees with it, can they consult other psychiatrists until they find one they do agree with? (see Section 8, Central Register). May the RMP take a different course than that recommended in the psychiatric assessment?
9. There are other ways to set down the minimum qualifications experience required of the psychiatrists to whom referrals may be directed (see Section 5, Definition of Psychiatrist).

Respondents raised the concern that referral to psychiatry to assess capacity to request AD/AS will become routine, rather than restricted to marginal cases where there is evidence of mental disorder affecting decision-making.

Conclusions:

1. RCPsychiS supports a role for psychiatrists in assessing capacity to request AD/AS when there is evidence of mental disorder which calls it into question.
2. RCPsychiS does not support referral to psychiatrists where this is not the case.
3. The Bill reverses the usual default presumption for capacity assessments.
4. Any additional work for psychiatrists arising from this Bill which falls outwith core business will require sufficient resourcing (see Section 12 below).

Recommendations:

1. The Bill and associated explanatory documents should be amended so that referral to psychiatrists only happens when there is evidence of mental disorder which calls capacity to request AD/AS into question.
2. The Bill should be amended to bring it into line with the AWI, restoring a default presumption of capacity until proven otherwise.
3. It should be recognised that additional work will require additional resource.

6. Definition of Psychiatrist

Section 7 of the Bill, quoted above, sets down minimum requirements for psychiatrists undertaking this role, referring to GMC recognition as a doctor who has completed higher psychiatric training and is the GMC specialist register. GMC registration is a UK wide function: and there may be advantages in referring instead to an existing and specifically Scottish status, namely approval under Section 22 of the MHA. Each of the Scottish Health Boards is required by law to maintain a list of RMPs who are also Approved Medical Practitioners (AMPs). This status confers specific legal roles and responsibilities under the MHA and AWI. (See Section 8, Central Register)

Conclusions:

1. AMP status may offer a more directly relevant minimum requirement for psychiatrists undertaking this role than being on the GMC specialist register.
2. It may be supplemented with additional minimum requirements, such as possession of MRCPsych, employment in a substantive consultant post, or GMC specialty accreditation.

Recommendation:

RCPsychiS recommends that Section 7 be amended to incorporate AMP status, possibly accompanied by other qualifications as listed above.

7. Minimum Age

The Bill declares in section 29 that the term "adult" means "a person who is aged 16 or over."

Other individuals, campaign groups or professional bodies will doubtless express views on the advisability, or otherwise, of the minimum age of eligibility being set at 16. Members of RCPsychiS have raised concerns about the specifically psychiatric implications of this threshold.

In Scotland, assessing and treating mental disorder in those under the age of 18 is normally the province of specialists in Child and Adolescent Mental Health Services (CAMHS). In other words, NHS service provision builds in an explicit age threshold at 17/18. In response to our survey, RCPsychiS members expressed a strong consensus view that psychiatric assessments of 16- and 17-year-olds requesting AD/AS should be undertaken by CAMHS specialists. Of the CAMHS specialists who responded to our survey, 46% were strongly or broadly opposed to legalising AD/AS, 33% were strongly or broadly in favour and 20% were undecided. 40% expressed a wish to opt out of participation, 27% said they would not, and 33% were undecided.

For these reasons, if no other, respondents argued that the minimum age proposed should be raised to 18. None argued that it should remain at 16. A small number argued that, given the psychological and neurophysiological and radiological evidence on brain maturation, it should be raised to 25.

Conclusion:

RCPsychiS is concerned that the minimum age proposed in the Bill is set too low at 16.

Recommendation:

RCPsychiS recommends that the minimum eligible age should be raised to 18, to bring it in line with NHS service provision within psychiatry, other legal thresholds in Scotland (such as buying alcohol) and the minimum age for AD/AS in other jurisdictions. Consideration should be given to raising it further, to the age of 25, in reflection of emerging scientific evidence about maturation.

8. Conscientious objection ("opting out")

Section 18(1) of the Bill states:

“An individual is not under any duty (whether arising from any statutory or other legal requirement) to participate in anything authorised by this Act to which that individual has a conscientious objection.”

RCPsychiS members welcomed this provision, which made explicit their ability to opt out and decline referrals, in contrast to previous Bills in this area. However, a number were concerned by Section 18(2) which states:

“In any legal proceedings the burden of proof of conscientious objection is to rest on the person claiming to rely on it.”

Some members took this to mean an unwelcome requirement to justify, in court, a position of conscientious objection, in proceedings reminiscent of those facing conscientious objectors to military service in WW1. In response to a previous Bill, RCPsychiS recommended that a simple declaration should be sufficient. In response to this Bill, members have drawn parallels with conscientious objection to participation in abortion procedures.

The Abortion Act 1967 provides for conscientious objection in very similar terms, and at section 4(3) states:

“In any proceedings before a court in Scotland, a statement on oath by any person to the effect that he has a conscientious objection to participating in any treatment authorised by this Act shall be sufficient evidence for the purpose of discharging the burden of proof imposed upon him by subsection (1) of this section.”

It is unclear why the current AD/AS Bill adopts only part of the relevant wording in the Abortion Act and omits that section dealing with the discharge of the burden of proof.

The Bill equates the terms “conscientious objection” and “opting out.” However, it is not clear that they are synonymous. Psychiatrists and other clinicians may choose to opt out for reasons other than a conscientious objection to assisted dying — for example out of a concern for the emotional welfare of other patients for whom they are responsible in their service.

Section 7 refers to the rights of individuals to opt out, but says nothing about institutions. In the psychiatric context this is potentially relevant to patients in long stay inpatient wards, community facilities, and forensic units, among others. This leaves open the question of whether such facilities can decline to accommodate AD/AS within their premises or, conversely, whether they can be required to do so. Clarity on this subject is necessary, and not just for psychiatric facilities. Similar concerns will apply to nursing homes, residential care settings, hospitals and hospices.

Opting out was the subject of a specific question in our membership survey. 47% declared a wish to avail themselves of this possibility. Though not quite a majority, this is a high proportion, which potentially confers a significant additional burden on those not wishing to opt out. It is possible that Section 18 (2) referred to above had a chilling effect on those wishing to opt out, with 25% classing themselves as undecided on this issue. If so, it is also possible that the introduction of a clause comparable in content to that in the Abortion Act might increase the number willing to opt out, taking it into the majority.

Conclusions:

1. A high proportion of RCPsychiS members have indicated a preference to opt out of participation in AD/AS.
2. The failure to adopt the clause about discharging the burden of proof of conscientious objection in the Abortion Act, while adopting other elements of it, troubles members.

Recommendations:

1. RCPsychiS recommends amending the Bill to adopt clause 4(3) about discharging the burden of proof of conscientious objection found in the Abortion Act 1967.
2. National decision-makers charged with implementing the Bill's provisions (if enacted) will need to prepare for a high opt-out rate among psychiatrists receiving referrals for assessment of people requesting AD/AS.

9. Opting in to a central register

In response to a previous Bill on this issue, RCPsychiS recommended that consideration be given to the establishment of a central register of psychiatrists willing to undertake the assessments envisioned in the Bill. There is a precedent for such a register in the lists of psychiatrists willing to undertake specific second opinion and tribunal hearing roles in regard to the MHA.

There is a possible further precedent in the list of Independent Assessors (IAs) held by the Human Tissue Authority (HTA), the statutory regulator of live organ transplantation (amongst other responsibilities). IAs are appointed and overseen centrally, after HTA-provided training, and assigned to transplant units and the centres which refer into them. In cases of proposed live organ donation IAs are required to interview potential organ donors and recipients, both separately and together, to confirm their identities and the nature of the biological or emotional relationship between them. They have specific responsibilities to confirm the donor has decision-making capacity, and a full understanding of the process and risks of donation. There is also a specific responsibility to confirm there is no evidence of coercion, pressure or duress upon either donor or recipient, and no evidence of financial reward or other improper incentive.

While most IAs are doctors, it is not an exclusively medical role, and increasingly one taken by nurse specialists, social workers, hospital chaplains and others. The IAs make their reports to the central body, the HTA, who make a decision to approve a proposed transplant. To proceed without HTA approval is illegal, and the law in England and Wales has recently been extended to make it a criminal offence to fail to report to the police (via the HTA) cases of suspected coercion or covert payment for donation. Scotland is considering following suit.

While the differences between live donor transplant and AD/AS are obvious, the IA role has some features in common with the assessment proposed in the Bill of those requesting AD/AS, specifically the confirmation of capacity and the exclusion of coercion or financial incentive. The role has been in place since 2006, and generally works well. Drafters of the current Bill for AD/AS may wish to explore what they can learn from the HTA, in order to make appropriate amendments.

While the proportion of those responding to our survey who wished to opt out was high at 47%, the proportion of those willing to opt in to a central register was significantly lower, at

16%. The opt-out rate is high enough to potentially cause problems for patients requesting AD/AS who need psychiatric assessment and cannot access it. The “opt in” rate of those willing to join a central register, if it is sufficiently resourced, may well be enough to ensure access.

Establishing a central register would address concerns raised by members about the emotional toll exerted by such cases, particularly in those who are reluctant to participate but hesitant about declaring a wish to opt out. This has a particular focus in psychiatry, where doctors’ core business includes treating patients to prevent their suicide, often against their will, via the MHA. To do this for one patient, and then to do quite the opposite for the next, requires an ability to recalibrate which some, perhaps many, psychiatrists would find unduly demanding.

A central register would also help ensure that psychiatrists willing to participate represent all potentially relevant areas of practice, whether broken down by location, or subspecialty.

A central register also offers other, less personal, advantages in terms of oversight, governance, training, quality assurance, central data collection, mutual support and research. It would make much less likely the emergence of “maverick practitioners” as has been observed in other jurisdictions. It should also be possible to address the “doctor-shopping” issue identified above: if a referring RMP disagrees with the conclusion of a psychiatrist listed on the central register, they could request a second opinion but only via the register.

A further potential benefit of establishing a central register is that it provides an answer to the questions raised in section 5 of this response, namely whether or not undertaking such assessments is part of the core business of front-line psychiatrists. If a central register were established, such work would clearly form part of the core business of the psychiatrists who were listed on it, and not of the psychiatrists who were not listed on it but who might otherwise be called upon. Work of this nature would need to be specifically resourced, but the funding would be specifically and closely aligned with the clinical activity, in a way which would be transparent and easily measured.

Conclusion:

RCPsychiS supports the establishment of a central register of psychiatrists willing to undertake this work.

Recommendation:

RCPsychiS recommends that drafters of the current Bill explore the precedents described above, and that the Bill is amended to include the requirement to establish a central register of psychiatrists willing to undertake this work.

10. Coercion

A previously proposed Bill to legalise end of life assistance in Scotland assigned to psychiatrists the responsibility to assess candidates for evidence they were subject to coercion, duress or pressure in making their request. RCPsychiS responded with a clear statement that psychiatrists have no more ability to assess and exclude coercion than any other doctor or non-medical practitioner. A subsequent Bill then assigned that responsibility

elsewhere. RCPsychiS welcomes the fact that this remains the position in the current Bill, but notes that all the Bill says about coercion are two brief identically worded references in Section 6 (Medical Practitioners' Assessments). These require the coordinating and independent RMPs to confirm that the person who has made a declaration that they wish to be lawfully provided with assistance to end their own life has:

"… made the declaration voluntarily and has not been coerced or pressured by any other person into making it."

Sections 6 (2) c and 6 (4) c

Assessing coercion is not a medical skill, though evidence of it may emerge during medical assessments. This may be more likely in specifically psychiatric assessments rather than those made by GPs, physicians or other specialists, but it does not follow that psychiatrists have any special expertise in the area. All clinicians who uncover such evidence need more guidance than is provided by the Bill or its explanatory notes on how to proceed if evidence of coercion does emerge.

The small but growing practice of "dual euthanasia" in other jurisdictions, notably Holland, raises further questions about possible coercion upon the less determined member of a couple seeking to die together. These are akin to the questions facing psychiatrists in cases of survival after suicide pacts. "Dual AS/AD" is not provided for in the Bill, but nor is it excluded. Psychiatrists and other doctors required to assess possible coercion in such cases will need guidance in how to go about it.

An issue of greater concern than coercion by external individuals, is an internal sense of duty or obligation to request assisted dying arising from a patient's view that he or she is a burden to others, whether financially or in the provision of support. The Bill and associated notes say nothing about how this concern might be addressed, or how to proceed if evidence of it emerges.

Conclusion:

RCPsychiS welcomes the Bill's recognition that assessing coercion is not a role in which psychiatrists have any greater expertise than other practitioners. However, the College is concerned that the Bill and associated explanatory notes say little about how psychiatrists or other clinicians should act if evidence of coercion emerges during their assessments, and further concerned that the Bill and explanatory notes say nothing about the assessment of an internal sense of duty or obligation in people seeking assistance to end their lives.

Recommendation:

RCPsychiS recommends that the Bill and/or associated explanatory notes provide more detail about the consequences of identifying external coercion or internal obligation as motivating factors in requests for AD/AS.

11. Death certification

The Bill states, in Section 17 (2):

"For the purposes of section 24 (certificate of cause of death) of the Registration of Births, Deaths and Marriages (Scotland) Act 1965, the terminal illness involved is to be recorded

as the disease or condition directly leading to their death (rather than the approved substance provided to them by virtue of section 15)."

This is misleading to the point of dishonesty, particularly when the falsification of death certificates in other contexts is now, and will remain, a criminal offence. It is inconsistent with current and proposed practice in other jurisdictions, and fundamentally inconsistent with principles of openness and transparency declared in association with the Bill.

From a specifically psychiatric perspective, such misleading recording will distort the collection of suicide statistics, undermining long-standing research in this area and making it difficult if not impossible to judge the effects of suicide prevention programmes.

That this is not a marginal concern is illustrated by the numbers projected and already encountered elsewhere. Explanatory notes associated with the Bill predict there will be 400-500 cases of assisted suicide per year 20 years after the Bill is enacted into law. This compares with the 600-700 people who die by suicide each year in Scotland. If deaths by assisted suicide are classed on death certificates as suicides, the apparent suicide rate in the country will increase by 50% or more. If many of the people who access assisted suicide and have their deaths attributed to the underlying qualifying illness would otherwise have died by unassisted suicide, the apparent suicide rate will go down by an unknown but possibly substantial margin. This makes it impossible to track the true rate of unassisted suicide. The figure of 400-500 per year may well be substantially underestimated, judging by the experience of rapid expansion in assisted dying in Canada, to a level now approximately double that of unassisted suicide.

Conclusion:

RCPsychiS has serious concerns at the provision for misleading certification of death proposed in the Bill.

Recommendation:

RCPsychiS recommends that death should be certified accurately, by introducing the category of Assisted Dying/Assisted Suicide into death certification, to distinguish it from unassisted suicide, with secondary certification for the underlying illness. For example - Cause of Death: Assisted Dying/Assisted Suicide in consequence of disseminated lung cancer.

12. Resources

Explanatory notes linked to the Bill state that costs are expected to be "low" and "absorbed within existing budgets". There is deep scepticism within RCPsychiS about both statements, with many members concerned that the additional demand on their already stretched services will be substantial, especially if they come with expectations of an urgent but unfunded response. The projected 20-year numbers and extrapolation from Canada referred to previously support this scepticism.

In response to the hypothetical counter-argument that shortening the lives of those currently dependent on expensive medical treatment and social care support will actually save money overall, RCPsychiS concedes this may well be true. But the argument exposes the possibility

of an unintended, but deeply troubling, perverse incentive to grant AD/AS while motivated in part by economic reasons. It also neglects the fact that while the actual process of delivering AD/AS may be cheap, and it may avoid the cost of helping someone remain alive, the costs of assessing people for AD/AS may well be substantial, and will fall on services which do not benefit from cost reductions.

Conclusions:

1. RCPsychiS is not reassured that the costs of assessing people for AD/AS will be low.
2. RCPsychiS does not accept that these costs can be absorbed in existing budgets.
3. RCPsychiS takes the view that any additional work arising from requests for psychiatric assessments for AD/AS will require additional resource.

Recommendation:

1. RCPsychiS recommends that the explanatory notes are amended to provide more realistic estimates of the additional costs expected.
2. RCPsychiS recommends an explicit statement that these additional costs will need to be measured as part of monitoring of the operation of the Bill if it becomes law.
3. RCPsychiS recommends an explicit statement that these new costs will be ring-fenced, covered by new investment, and not compensated by cutting services elsewhere. New work requires new resources.

13. Reciprocity

The Mental Health (Scotland) Act 2003 embodied 10 explicit principles, the fourth of which is reciprocity, defined as:

“Reciprocity - Where society imposes an obligation on an individual to comply with a programme of treatment of care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.”

It can be argued that an analogous principle of reciprocity should apply in the field of AD/AS. If someone with an eligible condition seeks AD/AS because the treatment and support they receive from medical and social care services is insufficient to make their suffering bearable, then does there not exist an obligation on those services to provide appropriate care and support before extending any offer of assistance in dying?

Embedding such a principle within an Act to legalise AD/AS carries with it a risk of introducing perverse incentives, whereby people make insincere requests for assistance in dying precisely in order to access services they cannot otherwise receive. It also carries the risk of distorting service provider’s priorities, so that the services they provide are channeled disproportionately to those who seek assisted dying, to the detriment of those who do not, even if they have eligible conditions.

While these risks are acknowledged, the converse risk is already concretely manifest in other jurisdictions, notably Canada, in reports of people who cannot access help to live being offered help to die instead.

Conclusion:

RCPsychiS sees value in exploring the extension to the field of AD/AS of the principle of reciprocity embedded in the current MHA since 2003.

Recommendation:

If the Bill passes Stage 1, RCPsychiS recommends that consideration be given to embodying the principle of reciprocity in subsequent amendments, and that guidance be brought forward as to how the principle is to be effected.

14. Special populations

There are subgroups of patients who live in various forms of institutional care, collectively described here as “special populations”. These settings broadly break down into long-stay psychiatric inpatient or community facilities for patients in LD, rehabilitation or old age psychiatry services, and residents in forensic psychiatry facilities (including the State Hospital at Carstairs), as well as inmates in Scottish prisons.

In some of these settings psychiatrists are the primary providers of medical care and thus may receive requests to act as coordinating RMPs for the purposes of this Bill. A significant proportion of their patients may be subject to MHA detention or AWI guardianship orders intended to maximise patient welfare, including the prevention of their suicide. Should any of them develop conditions which render them eligible for AD/AS, their psychiatrists may then be obliged to prevent their unassisted suicide via the MHA and/or Guardianship and, at the same time, facilitate their assisted suicide via AD/AS. This is legally, ethically and emotionally complex territory for such clinicians.

In prison settings, forensic psychiatrists will not be the primary providers of non-psychiatric health care, but will be the psychiatrists most closely involved, and are likely to be asked to make assessments of capacity under the Bill. A core part of a forensic psychiatrist’s role is the assessment of suicidal risk amongst prisoners, and the treatment of underlying mental illness which might drive it. Should any prisoner develop a condition which renders them eligible for assisted dying, it will fall to forensic psychiatrists to assess capacity in a way which may facilitate AD/AS while simultaneously attempting to prevent unassisted suicide. This again is complex territory, and made more so for prisoners serving long sentences who may prefer death to seeing out their term.

Conclusion:

RCPsychiS is concerned that there are various “special populations” in whom the implementation of AD/AS legislation may pose particular challenges for their clinicians and the institutions in which they reside. RCPsychiS has no specific recommendations to make in this regard, other than to urge recognition that such populations do exist, and that extending AD/AS to them, if it is legalised elsewhere, will raise concerns and questions not addressed in the Bill or explanatory notes.

15. Gaps between legislation and code of practice

If the Bill passes into law there will be a need for secondary legislation and regulation to cover matters of detail. RCPsychiS anticipate there will be also be a need for a code of

practice drawn up in cooperation with various stakeholders, and that for matters relating to psychiatry RCPsychiS will be among them.

When legislating in areas as complex and ethically nuanced as AD/AS there is a risk, indeed a likelihood, that legislators skip over difficult matters of detail in primary legislation with the unspoken expectation that the answers are provided at a later stage. However, as the foregoing clearly shows, there are many devils in the detail. RCPsychiS is willing to assist in developing those parts of a code of practice relevant to psychiatry, but would wish to do so on the basis of a clear understanding of legislators' intentions, which can then be interpreted in guidance to practitioners. Legislation is sometimes silent on legislators' intentions, leaving room for doubt on issues which cannot be dismissed as mere matters of detail because they are literally matters of life and death to the individuals involved.

Conclusion:

RCPsychiS is concerned that there is a risk of significant gaps between primary legislation and an eventual code of practice recommendation arising from lack of clarity over legislators' intentions.

Recommendation:

RCPsychiS recommends that if the Bill passes stage one it is subsequently amended to include a prefatory list of principles to guide its subsequent implementation. There are precedents for this in two major areas of Scottish legislation directly affecting the practice of psychiatry, namely the MHA of 2003 and the AWI of 2000.

16. Research and routine data reporting

Legalising AD/AS will be a substantial change in Scottish society, and one which will raise many questions. These can only be answered on the basis of adequate data. It is therefore crucial to establish, ahead of any implementation, a comprehensive system of data gathering for all aspects of this new practice, including those relating to psychiatry.

Section 24 of the Bill covers some of the data to be collected, but says nothing about the proportion of cases in which there is psychiatric assessment, or the associated outcomes.

Section 27 of the Bill proposes a five year review, taking into account annual reports, but is vague on the content of those reports.

There is a clear need for a comprehensive data set to be agreed in advance, with data collected prospectively, for analysis and publication in annual reports until at least the five year review and very probably after that. Given the scale of the shift in practice proposed in the Bill, and speed of changes observed in Canada well within five years there, it would be irresponsible to defer analysis for a period so long.

Conclusion and recommendation:

The only way to answer questions about how AD/AS works in practice, if it is implemented, is with robust data, gathered routinely at the centre, analysed and reported regularly, and open to additional analysis by external research groups. This will require resources. RCPsychiS is willing to advise on what specific psychiatric data should form part of a

minimum data set in an amended Section 24. Comprehensive reporting and analysis of emerging data should be undertaken annually, and not left to a five-year review.

17. Extension to mental disorder in future legislation

RCPsychiS is reassured that this Bill is not intended to apply to those with mental disorder but no qualifying terminal illness. However, some respondents cited the experience observed in some jurisdictions elsewhere (notably Canada) of the “slippery slope” argument. When AD/AS was introduced there, it was at first intended only for those with a “reasonably foreseeable death” excluding people with mental disorder. Rights-based arguments meant subsequent legislation extended eligibility to people with non-terminal but serious physical illness causing intolerable suffering. Further rights-based arguments have extended eligibility to people with mental but not physical disorders from 2027.

Other respondents cited other jurisdictions where this extension has *not* happened, indicating a slide down the slippery slope is not inevitable.

Whatever the merits of these competing arguments, there is no doubt that a slippery slope progression is possible, and this is matter of profound concern to RCPsychiS members insofar as it relates to people with mental disorder. A clear majority of respondents to our survey — 69% — were broadly or strongly opposed to extending the offer of AD/AS to people with mental but not physical disorder: 13% were in favour, and 18% were undecided.

Conclusion:

RCPsychiS is reassured that the current Bill does not apply to people with mental but not physical disorder. However, members are concerned that future legislation may, particularly if the practice is legalised for an initially restricted group, with those restrictions subsequently extended.

Recommendation:

RCPSychiS recommends that consideration be given to inserting a clause in the Bill itself, or in the associated documents, to the effect that any subsequent proposals for extension of eligibility for AD/AS to other groups must be firmly based on evidence in the form of carefully analysed, routinely collected robust data.

Appendix 1: RCPsychiS Member Survey: Assisted Dying for Terminally Ill Adults (Scotland) Bill

Overview

The Assisted Dying for Terminally Ill Adults (Scotland) Bill has recently been introduced to Holyrood, and the consultation process will open shortly.

The Royal College of Psychiatrists in Scotland (RCPsychiS) will submit a written response to the assigned scrutinising committee(s), informed by a survey of its membership.

It is not the intention of this survey to establish whether the College in Scotland is in favour or opposed to the principle of assisted dying for terminally ill adults. We hope to capture an outline of the breadth of views we know exists within the College in Scotland so that we can respond to the specific provisions of the Bill which relate to psychiatry, its practice and its professionals.

Centrally, RCPsych has established a working group on the general issues of principle raised by proposed Assisted Dying legislation across different jurisdictions (currently Scotland, Jersey, Isle of Man, and potentially England and Wales), and the group expects to publish an organisation-wide position statement in the next year. This statement may be used as a basis for engagement with proposals on assisted dying across the UK and in Crown Dependencies, and for public statements. The College will be surveying the UK membership on these general issues in the coming months.

Documents linked to this Bill include estimates of expected numbers of assisted dying deaths should such a service be implemented (25 in year 1, 50-100/yr in year 3-400/yr in year 20) plus associated costs, which are expected to be "low" and "absorbed within existing budgets". Concerns on these estimates have already been raised, and discussed, by College Officers and will form part of our response.

Assisted Dying for Terminal Illness

The Bill provides for assisted dying, in the form of the provision of medication which a patient takes themselves. To be eligible, the patient must be suffering from a terminal illness, defined as:

"...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."
(Section 2)

Separate to any concerns you may have about how an assisted dying service may operate in practice, what is your general view about assisted dying for eligible terminally ill adults under this definition?

- Strongly in favour
- Broadly in favour
- Neutral/undecided
- Broadly opposed
- Strongly opposed

Assisted Dying for Mental Disorder

Possible extension in future legislation

The Bill is not intended to apply to those seeking assisted dying for mental disorder (which is available in some, but not all jurisdictions elsewhere). The question has been raised about possible extension in future Bills to people with non-terminal physical illness and then, via parity of esteem, to those with any potential or possible mental disorder.

Exclusion for the Current Bill

On the subject of eligibility, section (3) (2) states:

"A person has capacity to request lawfully provided assistance if they -
(a) are not suffering from any mental disorder which might affect the making of the request, and
(b) are capable of -

1. understanding information and advice about making the request,
2. making a decision to make the request,
3. communicating the decision,
4. understanding the decision, and
5. retaining the memory of the decision."

What is your view about assisted dying for mental disorder in possible future legislation?

- Strongly in favour
- Broadly in favour
- Neutral/undecided
- Broadly opposed
- Strongly opposed

Exclusion from current Bill

This raises several questions, such as what this might mean for the eligibility of people with anorexia nervosa, dementia with retained capacity, and mental disorder co-morbid with terminal illness. The complexities do not lend themselves to simple survey questions, but we wish to capture them in our submission.

Please provide any views (250 words max)

Opting out

The Bill requires that if either of two assessing doctors is unsure about a patient's capacity (including the possibility their decision-making is influenced by mental disorder), they should refer to a psychiatrist. It also provides clinicians, including psychiatrists, with the possibility of an opt-out on grounds of conscience (Section 18 (1)).

[Section 18 (2) goes on to state, without elaboration:

"In any legal proceedings, the burden of proof of conscientious objection is to rest on the person claiming to rely on it."

Would you seek to opt out from this role?

- Yes
- Undecided
- No

Opting in to Central Register

In response to a previous Bill, RCPsychiS suggested a central register of psychiatrists willing to undertake this role (akin to the list of second opinion doctors held by the Mental Welfare Commission/ Mental Health Review Tribunal)

If such a register were established, would you wish to join it?

- Yes
- Undecided
- No

Age limit

The Bill sets a lower age limit for eligibility for assisted dying at 16. Patients aged 16 or 17 who need psychiatric assessment of capacity to make a relevant decision or mental disorder would normally be seen by CAMHS specialists in other contexts.

Who should undertake assessments of capacity in 16 and 17 years olds seeking assistance in dying?

- CAMHS specialists
- Adult specialists
- Either
- Both

- Other

If other, please state

About you

What stage of training/practice are you at?

- Medical Student
- FY doctor
- Core training role
- Staff Grade role
- Associate Specialist
- Consultant
- FRCPsych
- Retired

In what sub-speciality do you currently work

- GAP
- Old Age
- CAMHS
- ID
- Forensic
- Psychotherapy
- Addictions
- Liaison
- Neuropsychiatry
- Eating Disorder
- Perinatal
- Other

If other, please state

Where do you currently work/study?

- Urban
- Rural/Semirural
- Remote/Island

Final Comments

Do you have any final comments? (250 words max)

Authentication and Anonymity Statement

This survey has been devised to obtain the views the membership in Scotland, and we ask that you provide your College membership number.

We have opted to include this measure to ensure the survey is answered by members of the College in Scotland, and only members of the College in Scotland.

You must provide this information to submit your response.

Please be assured your response will be treated with strictest confidence and will not be identifiable, either via the RCPsychiS response to the Bill or otherwise. This is the main reason we haven't sought more specific demographic information.

We plan to use your free text responses to inform and develop our positioning, and sense-check our conclusions, rather than quote verbatim. If you are concerned that a combination of your answers about level of training, sub-speciality and location make you more identifiable than you wish to be, please feel free to omit answers.

Please provide your RCPsych Membership Number:

Appendix 2: Headline Figures

1. Separate to any concerns you may have about how an assisted dying service may operate in practice, what is your general view about assisted dying for eligible terminally ill adults under this definition?

   Strongly in favour: 21%
   Broadly in favour: 24%
   Neutral/Undecided: 14%
   Broadly opposed: 19%
   Strongly opposed: 22%

2. What is your view about assisted dying for mental disorder in possible future legislation?

   Strongly in favour: 5%
   Broadly in favour: 8%
   Neutral/Undecided: 18%
   Broadly opposed: 26%
   Strongly opposed: 43%

3. Would you seek to opt out from this role?

   Yes: 47%
   Undecided: 25%
   No: 28%

4. If such a register were established, would you wish to join it?

   Yes: 16%
   Undecided: 24%
   No: 60%

5. Who should undertake assessments of capacity in 16 and 17 years olds seeking assistance in dying?

   CAMHS Specialist: 61%
   Adult: 0%
   Both: 13%
   Either: 8%
   Other: 18%