BMA Scotland response to the Health, Social Care and Sport Committee's call for evidence on the Assisted Dying for Terminally Ill Adults (Scotland) Bill

Question 1

Neutral

The BMA represents members with a wide range of views, and this is reflected in our neutral position which was adopted at our Annual Representatives Meeting (ARM) in September 2021. The debate that led to our shift from opposition to neutrality was informed by an all-BMA member survey undertaken in 2020 which received nearly 29,000 responses (including 3,574 doctors based in Scotland); the results of the survey can be found https://www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying/physician-assisted-dying-survey.

Our neutral position means that we neither support nor oppose a change in the law, but we have been clear that we have a responsibility to protect and represent our members in discussions on any legislative proposals. Whilst we do not have a position on the principle of whether or not the law should change, we do have concerns about how some key aspects of the Bill, as currently drafted, would impact on our members and patients. We would therefore want to see more thought given to how any such service would be delivered in practice (see our comments below) as part of the legislative process.

Which of the following factors are most important to you when considering the issue of assisted dying?

Impact on healthcare professionals and the doctor/patient relationship

Other

Our members will assign different levels of importance to the factors listed in the question when considering the possibility of legislative change, based, in part, on their views on assisted dying itself. As the professional association and trade union representing doctors, the BMA's views are focussed on those issues that would have a significant impact on our members should the law change. The BMA's positions expressed in this response were developed through a detailed piece of work by the BMA's Medical Ethics Committee and have been approved by all four BMA Councils (UK, Scotland, Wales, and Northern Ireland). More information can be found https://www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying/.

For the avoidance of doubt, by responding to this call for evidence, we are not supporting or opposing a change in the law. These comments are provided solely to inform the committee of the BMA's views on some key issues if the law were to change. Where we have not commented on the Bill, this is because it is not an issue

that we have currently taken a position on – it should not be interpreted as support for, or acceptance of, those provisions.

Question 2

Other

The BMA has not taken a position on which patients should be eligible for assisted dying, or the definition of terminal illness. Nevertheless, we have said that the legal requirements and eligibility criteria must be absolutely clear and unambiguous.

Although the policy memorandum (at para 32) clarifies that 'It is not the intention that people suffering from a progressive disease/illness/condition which is not at an advanced stage but may be expected to cause their death (but which they many live with for many months/years) would be able to access assisted dying', this is not explicit in the Bill itself which could potentially lead to uncertainty about an individual's eligibility. The lack of clarity around the term 'premature' is likely to be problematic for coordinating and second opinion doctors who are required to confirm that the criteria are met; any such ambiguity in the eligibility criteria could leave those doctors open to challenge and/or complaint.

Which of the following most closely matches your opinion on the minimum age at which people should be eligible for assisted dying?

Other

The BMA has not taken a position on which patients should be eligible for assisted dying if the law were to change. Nevertheless, in the work the BMA has done on assisted dying, including in the survey we conducted in 2020, we have assumed any law would apply only to 'adults' who have the mental capacity to make the decision and have made a voluntary request. In England, Wales and Northern Ireland an individual is considered an adult at 18 years old; in Scotland it is 16. BMA Scotland has not specifically considered the question of whether there are grounds to apply a higher (or lower) minimum age for eligibility for assisted dying than for other decisions.

Question 3

Other

The BMA has not taken a position on the safeguards that should in place but has considered the process through which any assisted dying service should be delivered.

The BMA does not support the proposal, reflected in the Bill and supporting documentation, that assisted dying would be provided by the patient's own GP, or specialist doctor, as part of the standard care and treatment they provide.

In the BMA's view, assisted dying should be arranged, but not necessarily delivered, through a separate service that would accept referrals from other professionals and/or self-referrals. (This does not necessarily mean separate from the NHS.) The service should be staffed by doctors, and others, who have positively chosen to opt-in to provide assisted dying (see Q5). Doctors who wanted to do so, could still assist their own patients, but this would be arranged, and potentially managed, through a different pathway. The model proposed in Jersey, whereby the Jersey Assisted Dying Service (https://statesassembly.gov.je/assemblypropositions/2024/p.18-2024.pdf?_gl=1*1s1e05f*_ga*ODc5ODQ4MjMyLjE3MDU0MjExNTc.*_ga_07GM08Q17P*MTcxNDA1NzgyNi4xNi4xLjE3MTQwNTc4MjYuMC4wLjA) would 'coordinate and deploy the professionals' who would provide the service, provides an example of how this could work.

The advantages of having this separation include that it would:

- help to reassure those doctors who did not want to participate that there would be no pressure on them to do so;
- give patients a clear pathway to access the service that would not be dependent on the views of their treating doctor;
- ensure that those doctors participating in assisted dying would have the necessary training, experience and both practical and emotional support; and
- help to ensure consistency and facilitate oversight, research, and audit of the service.

The BMA is also very concerned by the suggestion in the financial memorandum, that 'registered medical practitioners (RMPs) would undertake the role as part of their existing employment and thus that costs would be absorbed by existing budgets'. NHS Scotland is under-staffed, under-resourced and under-funded. Additional services cannot be placed on doctors without adequate resourcing and funding. If the Scottish Parliament decides to change the law on assisted dying, the Scottish Government must make sufficient additional funds available to ensure that the service is properly resourced without adversely impacting on existing healthcare services.

Question 4

Other

The BMA has not taken a position on this.

Question 5

Other

The BMA believes that any legislation to permit physician-assisted dying should be based on an 'opt-in' model of delivery for doctors, so that only those who positively choose to participate are able to do so. Doctors who opt in to provide the service should also be able to choose which parts of the service they are willing to provide (e.g. assessing eligibility and/or prescribing drugs to eligible patients).

From the information we have gathered about other jurisdictions, it appears that in practice assisted dying is usually only provided by those who positively choose to participate, even though it is not explicitly presented in this way. (In some jurisdictions for example, only those who choose to undertake the required mandatory training, or to register with a central body, are eligible to participate.) Making this explicit in any legislation would provide reassurance to both doctors and patients.

An opt-in model for doctors to provide assisted dying would:

- give doctors the greatest amount of choice about whether, and if so the extent to which, they were involved;
- provide reassurance to those doctors who did not want to participate that they would not face pressure to do so;
- ensure that those who wanted to participate had the proper training and experience to do so;
- make it easy for patients seeking assisted dying to identify a doctor willing to help them; and
- make the service easier to audit, which would help to build confidence and maintain trust.

Policy proposals in Jersey and the Assisted Dying Bill in the Isle of Man are both now based on an opt-in model (with the House of Keys in the Isle of Man supporting amendments to effect this, following the BMA's briefing.)

Doctors who do not choose to provide assisted dying themselves, under an opt-in model, could still receive requests from patients or other health professionals for actions that form an intrinsic part of the assisted dying process. These are activities that would require them to use their professional skills and judgement to facilitate a request for assisted dying. This could include, for example, a request to assess an individual's capacity, or make a judgement about their life-expectancy, specifically in order to assess their eligibility for assisted dying.

The Bill currently includes a conscientious objection clause similar to that found in legislation on abortion and assisted reproduction (but with a higher burden of proof for those wishing to rely on it). The BMA believes that, if assisted dying were legalised, doctors should be able to decline requests to carry out these types of activities for any reason. Therefore, there should be a general right to object which does not need to be based on matters of conscience. If it was considered important to retain some reference to conscience in the Bill, this could be achieved by modifying the wording to indicate that a decision not to participate may be for

reasons of conscience or for any other reason (and the removal of clause 18(2) which would become redundant)

We are aware (including from responses to our survey) that there are some doctors who do not oppose assisted dying in principle (and so do not have a 'conscientious' objection in the way that is normally understood) but who would not personally want to participate in the process. These doctors need protection under the Bill. It is important, therefore, that if assisted dying were legalised, doctors should be able to object to taking any direct part in the process itself, for *any reason* and, as such, any right to object should not be framed as, or limited to, matters of conscience. There is some evidence from Quebec that supports this position; many doctors who claimed a conscientious objection did not cite moral or religious objections to assisted dying but expressed other reasons for not wanting to participate such as the emotional impact of participation, lack of time, and lack of confidence in their competence to carry it out (A qualitative study of physicians' conscientious objections to medical aid in dying - Marie-Eve Bouthillier, Lucie Opatrny, 2019 (sagepub.com) https://journals.sagepub.com/doi/10.1177/0269216319861921 Palliative Medicine Vol 33(9))

In terms of moral complicity, there is a difference between requests for doctors to use their professional skills as part of the process of assisted dying, which the BMA believes doctors should be able to refuse for any reason, and requests to provide existing information from the medical record, which the BMA believes all doctors should comply with, without delay. Irrespective of their personal views, if approached about assisted dying, the BMA believes that all doctors should also inform patients about where and how to obtain information about assisted dying.

Both Jersey and the Isle of Man have accepted the BMA's position on this and are extending the right to object, in their legislative proposals, so that it does not need to be based on matters of conscience.

We are aware of the need for Westminster to give its approval to the inclusion of a conscientious objection clause in Scottish legislation which, as far as we can tell from the documentation accompanying the Bill, has not yet been given. However, having an opt in system combined with a general right to refuse may help to address some of these technical legal challenges.

The policy memorandum accompanying the Bill states, at para 52, that a doctor with a conscientious objection 'should refer the person to another registered medical practitioner who is content to participate'. Without an opt-in system and/or a separate service, it is not clear how a doctor would be able to identify a 'registered medical practitioner who is content to participate'.

The BMA supports the establishment of an official body (with legal accountability) to provide factual information to patients about the range of options available to them (see response to Question 8). For those who wish to pursue assisted dying, this body would also provide support to navigate the system, including finding a doctor who would be willing to help. This would enable doctors with a conscientious objection to direct patients to that organisation for information and support and would

allow patients to access information without needing to go through their doctor if they so wish.

Question 6

Other

The BMA has not taken a position on how assisted deaths should be recorded on the death certificate. It is essential, however, that there is clarity about what information should be recorded.

The explanatory notes (at para 46) say ‘It is expected that the use of the approved substance will also be recorded on the death certificate’ but this is not clear from the question, which implies there is no mention of assisted dying on the death certificate.

Assuming therefore that the intention is for both the underlying terminal illness and the use of the approved substance will be recorded on the death certificate, the question is where on the form the information is included. The BMA has not taken a position on that particular question but in our guidance on decisions about clinically assisted nutrition and hydration we say: ‘Following withdrawal of CANH, the immediate direct cause of death will usually be multi-organ failure or bronchopneumonia, whereas the underlying cause of death will be the original brain injury or medical condition’. To provide consistency with this established principle, and ensure continuity of data collection, we would suggest that a similar approach is taken for assisted dying.

Question 7

The reporting and review requirements should be extended to increase transparency

If assisted dying were legalised, the BMA would support the introduction of a system for routinely reviewing all assisted deaths as an important part of oversight and monitoring, to maintain trust and confidence in the service.

Review committees, to assess all deaths following assisted dying, have been set up in a number of countries including New Zealand, Australia, the Netherlands and Canada. Their role is to retrospectively review each individual case after a death has occurred, to ensure that the correct process had been followed. Any problems or breaches identified and requiring further investigation or action are then referred on to the relevant organisations. Reviewing the details of individual deaths – including identifying the time to death and any complications or unforeseen circumstances that arose – can also lead to improvements in how cases are managed from a medical perspective and help to identify learning points for those delivering the service.

The BMA also strongly supports the establishment of an independent and transparent system of oversight, monitoring and regulation of assisted dying. This is essential to ensure appropriate standard-setting, quality assurance and to maintain public confidence.

Question 8

No duty to raise the issue of assisted dying with patients

During the Medical Ethics Committee's discussions on assisted dying, the question arose of whether, if the law changed, doctors would be under be a common law duty to raise the issue of assisted dying with any patient who may be eligible. This suggestion is based on a possible interpretation of the Supreme Court judgments in the cases of Montgomery v Lanarkshire Health Board (https://url.uk.m.mimecastprotect.com/s/TuL3CVPOLu0YWGGuG3qxU?domain=supremecourt.uk) and McCulloch v Forth Valley Health Board (https://www.supremecourt.uk/cases/uksc-2021-0149.html), which concerned the scope of information that must be provided when seeking consent to treatment and (in the second case) doctors' duties to raise treatment options with patients.

The BMA's view is that assisted dying is not a 'treatment option' in the conventional sense. As such, our view is that there is, at present, no common law duty to inform patients of the potential that they can seek assistance with dying. Nor would that change if the law changed to make it legal to provide assistance with dying. When our Medical Ethics Committee discussed this, however, they accepted that the possibility of a court reaching a different conclusion in due course could not be completely discounted. This would only become clear if a complaint was made against a doctor and a judge would then be asked to decide on the scope of the duty to inform. We want to avoid any of our members facing any such challenge and so, for the avoidance of any doubt, the BMA would want to see specific provision in any legislation to make clear that there is no duty on doctors to raise assisted dying with patients if it were legalised. An amendment to the Assisted Dying Bill to this effect has been accepted by the House of Keys (Isle of Man) after the BMA raised this issue.

Protection from discrimination and abuse

If assisted dying were to be legalised, the BMA would want to see 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.

Through the work we undertook with our members, it became clear that some doctors were concerned about how their decision to participate, or not to participate, in assisted dying (if it were legalised) might impact on them both personally and professionally. This included concerns that they might be ostracised by colleagues, or their career prospects might be jeopardised, because of their decision. We also heard anecdotally about some healthcare institutions in other countries, that are opposed to assisted dying, using contractual terms to prevent their doctors from participating in assisted dying in their own time. Any discrimination, or detriment to

doctors, as a result of their views, and/or intentions, regarding assisted dying is unacceptable to the BMA and should be prohibited.

The BMA also believes that any Bill to legalise assisted dying should include provision for safe access zones that could be invoked should the need arise, to protect staff and patients from harassment and/or abuse.

The Scottish Parliament has recently passed the Abortion Services (Safe Access Zones) (Scotland) Bill (https://www.parliament.scot/bills-and-laws/bills/abortion-services-safe-access-zones-scotland-bill/introduced) to protect patients and staff accessing abortion services from harassment by protesters Given the strong views around assisted dying, it is possible that similar protests could take place close to facilities providing assisted dying. Although there is no evidence of harassment outside establishments in other countries, the BMA strongly supports the need to protect both staff and patients in the event of any harassment taking place. Safe access zones can only be put in place if the relevant legal powers exist. Therefore, if legislation were to be passed, the BMA believes it should include legal provision for safe access zones that could be invoked if the need arose.

In Jersey, the ministerial committee's report (https://statesassembly.gov.je/assemblypropositions/2024/p.18-2024.pdf?_gl=1*1s1e05f*_ga*ODc5ODQ4MjMyLjE3MDU0MjExNTc.*_ga_07GM08Q17P*MTcxNDA1NzgyNi4xNi4xLjE3MTQwNTc4MjYuMC4wLjA.) on 22 March 2024 announced that during the drafting of the Bill, consideration would be given to the introduction of statutory protection from discrimination and the provision of safe access zones. Amendments have already been accepted to the Isle of Man Bill to provide statutory protection for doctors in terms of their employment and a separate Bill is under consideration by the House of Keys making general provision for safe access zones.

Providing information to patients

If assisted dying were to be legalised, we would support the establishment of an official body (with legal accountability) to provide factual information to patients about the full range of options available to them, so that they can make informed decisions.

It is important that doctors who do not wish, or do not feel confident, to provide information to patients about assisted dying have somewhere they can direct patients to, in the knowledge that they will receive accurate and objective information. It is also important for patients who may meet the eligibility criteria to know where and how to obtain the information they need without the requirement to go through their doctor. The policy memorandum suggests that organisations such as Friends at the End and the Humanist Society Scotland have indicated that they would provide 'guidance, support, counselling and other navigation for patients' but the BMA believes that something much more formal, centralised and impartial is needed for this vital role. We therefore believe there should be an official body (with

legal accountability) to provide this information to patients and to help them to navigate the process.