GMC consultation on Guidance for the Investigation Committee and case examiners when considering allegations about a doctor's involvement in encouraging or assisting suicide

1. I write with regard to the GMC consultation on Guidance for the Investigation Committee and case examiners when considering allegations about a doctor’s involvement in encouraging or assisting suicide.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 44,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient–centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

3. The College welcomes the opportunity to respond to this consultation. We are supportive of the GMC’s efforts in producing this guidance and in putting it to wide consultation, since it addresses matters which are likely to be of particular concern to
our members. Our response to the questions should be seen in the context of our position statement on assisted suicide, which was formulated in 2005 and can be encapsulated as below:

“The RCGP believes that, with current improvement in palliative care, good clinical care can be provided within the existing legislation, and that patients can die with dignity. A change in legislation is not required.”

4. We have addressed the specific questions of the GMC consultation below:

**Legal context (paragraphs 2–4)**

1 **Do you think paragraphs 2-4 set out the legal context clearly?**

Yes, the section is clear. For the sake of completeness, the GMC might consider including the actual DPP guidance on factors to be considered, as referred to in paragraph 3 of the guidance, or at least providing a link to the same: [http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html](http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html). This would be useful to busy doctors who wish to apprise themselves of the key issues in a short space of time.

**Ethical guidance and principles (paragraphs 5–10)**

2 **Do you think this explanation of the ethical principles is helpful?**

Yes, and it is essential for context.

3 **Do you find these paragraphs (9-10) helpful?**

Yes, and they are appropriately placed. The key point, in paragraph 9, with regards to providing patients with ‘information that might encourage or assist them in ending their lives’ - that doctors should explain that ‘they cannot do so because providing this information would mean breaking the criminal law’ – is obviously necessary. It is well to place this immediately after paragraph 8, with its discussion of palliative and end-of-life care planning.

We have heard concerns that these guidelines may discourage doctors from discussing suicidal thoughts/ideation with their palliative care patients. If doctors feel that knowing about patient plans might be seen as implicating them as having encouraged such plans this would be problematic, as it might discourage doctors from having the frank and supportive discussions with patients that are to the benefit of patients and their families.
In the context of current improvements in the provision of palliative care (as referenced in our position statement above), doctors must be enabled and encouraged to have these kinds of discussions. Perhaps the GMC could consider an even more careful form of words to clarify the line between appropriate advice and information that would be illegal, so that doctors can have the confidence to do this useful work without fear.

Equality and diversity analysis (paragraph 13)

Are there any parts of this guidance which could result in discrimination against any of the groups of people with protected characteristics under the Equality Act 2010?

No, we do not believe there are.

Types of case: cases involving convictions, cautions and determinations (paragraph 15)

For each of the following, please indicate whether you agree, disagree or are not sure that a doctor should be referred directly to a fitness to practise panel:

1. When the doctor has been convicted
   We agree.

2. When the doctor has received a caution
   We agree.

3. When the doctor has been the subject of a determination by another regulatory body
   We agree
   As well as the concern for patient safety, this approach is important for the maintenance of public confidence in the profession. The Shipman case did much to undermine public confidence in this area, and it is therefore important that the GMC take a firm and consistent line.

Presumption of impaired fitness to practise
(Paragraphs 16–18)

Should we add any other circumstances to the list in paragraph 17?

No. Intent and the fact that doctor knew or could reasonably be expected to know that the actions would assist suicide are the basic factors for a criminal conviction. However we do suggest that advice or support for a family member should at least be given some consideration in a different light from a purely doctor-patient relationship.
7 Are there any other examples that could usefully be added to the list at paragraph 18?

No – however we have some reservations about paragraph 18b, and can foresee that this will be the source of future arguments and potential fitness to practise cases. The sentence is carefully worded – implicitly acknowledging that there are drugs which may be clinically indicated but which may cause or contribute to death at a level required to control symptoms. But there will surely be arguments over which drugs are not clinically indicated in some cases. In a worst case scenario, we can envisage that some doctors will decline to prescribe necessary drugs – opiates and anti-emetics – or feel restricted to prescribing for no more than a week at a time. This is a short paragraph which carries a lot of weight, and we would argue that it should be expanded for the sake of clarity.

Other serious or persistent failures to comply with GMC guidance (paragraphs 19–21)

8 Are there any other examples that we should include in paragraph 19?

No. However 19b is potentially contentious and should perhaps specify ‘solely for the purpose of helping a person… travel to a place where they will be assisted to [commit suicide]’ – since doctors may write reports on capacity for other, quite legitimate reasons, such as power of attorney, and run the risk of suspicion that they could be used to assist suicide abroad.

9 Are there any other factors which we should include in paragraph 21 that could help a decision-maker to decide whether there may be a public interest in taking further action?

The specification in 21b is confusing. Doctors are aware that professional standards apply at all times – a doctor who applied a different set of standards in their personal relations would also be likely to undermine public confidence in the profession – especially given the expectation in Good Medical Practice that doctors should avoid providing medical care to those with whom they have a close personal relationship. Perhaps it would be appropriate, in this paragraph, to consider whether the doctor had discussed the patient’s management with any other colleague.

Allegations that do not raise a question of impaired fitness to practise (paragraph 22)

10 Do you agree that the examples provided in paragraph 22 should not normally raise a question of impaired fitness to practise?
Yes, we would agree. In relation to paragraph 22b, the College is supportive of patients’ rights to access their records and would not want to see this obstructed for fear of investigations into assisted suicide.

11 Are there any other things a doctor might do relating to assisting suicide that should not normally raise a question of impaired fitness to practise?

No, not that we are aware of.

General questions about the draft guidance

12 Should the GMC give advice to the Investigation Committee and case examiners on this issue?

Yes, this is obviously an important issue and clarity is vital.

13 Is the draft guidance detailed enough?

Yes – it is important that it remains concise, so that it can give a clear, unambiguous message and be accessible.

14 Is the guidance clear?

Yes, with the reservations already mentioned above. It is in the nature of these matters that the clarity will be tested by individual circumstances.

15 Do you have any other comments on the draft guidance?

No.

5. We gratefully acknowledge the contributions of members of our Ethics Committee and medico-legal experts in formulating this response.

Yours sincerely

Professor Amanda Howe MA Med MD FRCGP
Honorary Secretary of Council