RCGP SCOTLAND

Stage 2 - Assisted Dying for Terminally Ill Adults (Scotland) Bill

Briefing from RCGP Scotland

RCGP Scotland is the membership body for general practitioners in Scotland, and we exist to promote and maintain the highest standards of patient care.

On 14 March 2025, the RCGP UK Council voted to move to a position of neither supporting nor opposing assisted dying being legal. The UK Council debate and subsequent decision was informed by an all-member survey that ran between January and February 2025.

In September 2024, UK Council agreed a set of principles, based on recommendations that should be applied if legislation is introduced to legalise assisted dying. These principles have fed into the College's ongoing influencing activity in response to the current legislative developments to ensure that any changes to the law protect the interests of all patients and healthcare professionals.

These principles include that:

- Any assisted dying service should be seen as a standalone specialised service that GPs and other healthcare professionals may opt to provide with additional training and should not be deemed core GP work.

- There should be a right for GPs to refuse to participate in the assisted dying process on any ground, and statutory protection making it unlawful to discriminate against them for doing so.

- An independent and transparent system of oversight, monitoring and regulation should be established.

- There should be a full and extensive consultation on defining the regulatory framework, standards and training for all those involved in delivering assisted dying services. Work to define standards and training for those involved in delivering assisted dying services would need to be conducted on a cross College, multi-professional basis.

- Any assisted dying service would need to be separately and adequately resourced and should not, in any way, result in a de-prioritisation of core general practice or palliative care services.

Further information, including copies of all our previous briefings and submissions can be found at: www.rcgp.org.uk/representing-you/policy-areas/assisted-dying

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Stage 2 amendments

Key amendments have been tabled at Stage 2 which go some way to meet our principles for assisted dying legislation. RCGP Scotland strongly supports these amendments and urges MSPs to vote in favour of the amendments at Stage 2.

Establishment of an opt-in model of participation for healthcare staff

Amendment #39	**Liam McArthur MSP**	**Strongly support**

If assisted dying is legalised, this would be a very significant change for health professionals and it is therefore essential that they are given a genuine choice about whether, and if so to what extent, they are willing to participate.

We urge the committee to support amendments from Liam McArthur MSP to section 18, which acknowledge that an assisted dying service should be set up as an opt-in model, so that only those health professionals who positively choose to opt in are able to provide the service. We welcome the removal of the need to prove grounds of conscientious objection.

There is a big psychological difference between assisted dying being something that all health professionals could be expected to participate in – unless they use the formal processes to opt-out – versus it only being expected of those who positively choose to opt-in.

There are several benefits to explicitly establishing an opt-in model:

- Given the significance of this change to the law, it appropriately gives health professionals the greatest degree of choice about whether, and if so how, they participate.
- It protects health professionals from being expected, and/or pressured, to undertake the training and participate.
- It avoids health professionals who do not want to participate having to invoke a formal process to achieve that.
- It ensures that staff who do choose to participate receive the in-depth training necessary, and are deemed competent, to carry out these complex roles.
- Staff who opt in would build up experience and have access to supervision and wellbeing support.
- As well as better supporting individual staff, this would also ensure high-quality patient care and experience.
- As well as being safer for staff and patients, we believe that providing a smaller cohort of health professionals who have opted in, with the in-depth training required, would be more cost effective than rolling out sufficiently in-depth training to a much wider cohort of health professionals who may, or may not, be asked (and/or be willing) to participate in assisting a death at some point.

Register of persons willing to carry out functions under the Act

Amendment #198 (and consequential amendments) **Miles Briggs MSP** **Strongly support**

Establishing a register of staff who have opted in would have the added advantage of making it easier for health professionals to direct a patient to a doctor who would fulfil the role of cRMP.

It would also make it easier for the coordinating (cRMP) to identify someone to fulfil the role of independent Registered Medical Practitoner (RMP) and, if required, an Authorised Health Professional (auHP). It would also allow Health Boards to accurately map the staff available locally to provide assisted dying.

Training requirements

Amendment #71 (and consequential amendments) **Jackie Baillie MSP** **Strongly support**

These amendments have been jointly proposed by RCN Scotland, BMA Scotland, Royal College of General Practitioners Scotland, Royal Pharmaceutical Society Scotland and Queens Nursing Institute Scotland.

Providing assisted dying would be a complex process with a number of different stages on which health professionals will require specific training. We strongly believe there should be a legal requirement for any health professional carrying out one of the functions under the Bill to have had specific training to do so. This would protect both health professionals and patients.

We envisage that training needs might include:

- carrying out all of the assessments that are necessary.
- ensuring the patient meets the legal criteria.
- ensuring the legal process has been followed (independent opinion etc).
- knowing how and what to prescribe.
- understanding what is permitted in terms of assisting the individual to self-administer the substance
- understanding how to manage any complications.
- ensuring all of the necessary legal forms and documents are completed and submitted appropriately.
- providing emotional support to the patient and the family.

While amendments 34A, 65 and 67 (Liam McArthur MSP) include “training” alongside “qualifications and experience,” in the list of things Ministers ***may*** specify in regulations relating to those who can take on the roles of cRMP, RMP and AuHP, there is no requirement for Ministers to do so.

Amendment 71 clearly sets out that Ministers ***must*** make provisions about the training that an individual must have completed in order to undertake the role of cRMP, independent RMP and AuHP. It also requires Ministers to consult with the relevant trade unions and professional bodies before laying such regulations.

We recognise that in addition to staff who are taking on the roles and functions outlined in the Bill, all health and care staff would need some training to ensure widespread awareness of the legal framework established in the legislation and where to direct patients who ask questions about accessing assisted dying. This amendment is not aimed at making any provision about this wider training requirement.

It is essential that the Bill makes clear that staff carrying out the functions under the Bill will have opted in and have completed the necessary training.

No detriment

Amendment #194 Miles Briggs MSP Strongly support

These amendments have been jointly proposed by BMA Scotland and the Royal College of General Practitioners Scotland.

The legislation should make 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.

In the Health, Social Care and Sport, stage 1, committee report, the committee stated: ‘The Committee notes evidence in support of a 'no detriment' clause or similar provision within the Bill to protect healthcare staff from potential workplace discrimination as a result of their decision either to be involved in the assisted dying process or to exercise a conscientious or other objection to being involved.'

Daniel Johnston’s amendment #11 only covers those who do not want to participate for reason of conscientious objection, we would like to see wider scope and allow no detriment or discrimination to any doctor whether choosing to participate or not, for any reason.

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No duty to raise, or prohibition on raising the issue of assisted dying with patients

Amendment #195 Miles Briggs MSP Strongly support

These amendments have been jointly proposed by BMA Scotland and the Royal College of General Practitioners Scotland.

There should be specific provision within legislation to make clear that there is no duty on doctors to raise assisted dying with patients if it were legalised. Doctors should be trusted to use their professional judgement to decide when and if a discussion about assisted dying would be appropriate, taking their cue from the patient as they do on all other issues.

Equally doctors should be able to talk to patients about all reasonable and legally available options; a provision that limits or hinders open discussion about any aspect of death and dying is likely to be detrimental to patient care.

A prohibition would also create uncertainty and legal risks for doctors, which may inhibit effective doctor/patient communication and understanding. Some patients find it difficult to bring up sensitive subjects in their consultations, and doctors are skilled at reading between the lines of what patients say and working out what has been left unsaid. They may therefore need to gently explore whether this is an issue the patient wishes to discuss. Official bodies in New Zealand and Victoria have raised concerns about the impact of this provision in their legislation and have recommended that it is amended.

An official service to provide information for patients

Amendment #197 (and consequential amendments) Miles Biggs MSP Strongly support

These amendments have been jointly proposed by BMA Scotland and the Royal College of General Practitioners Scotland.

The establishment of an official service to provide factual information to patients about the full range of options available to them would support patients to make informed decisions. This would ensure that doctors who did not wish, or did not feel confident, to provide information to patients about assisted dying had somewhere they could direct patients to, in the knowledge that they would receive accurate and objective information. It would also ensure that patients who may meet the eligibility criteria would be able to access the information they need without the requirement to go through their doctor and would have support to navigate the process.

The Nuffield Trust, in its recent report on the implementation of assisted dying legislation in 15 jurisdictions, recommends that policymakers consider other countries' examples of establishing dedicated care navigator roles to provide information on assisted dying and how to access the service, connect people with eligible clinicians, and offer support to families, carers, and health professionals.

A formal review of all assisted deaths

Amendment #199 (and consequential amendments)	**Miles Briggs MSP**	**Strongly support**

These amendments have been jointly proposed by BMA Scotland and the Royal College of General Practitioners Scotland.

There should be a system for routinely reviewing all assisted deaths to ensure that the correct process was followed, and to identify learning points to improve the management of cases, if assisted dying were legalised. Review committees are common in countries that have legalised assisted dying.

Provision of the service

Amendment #264	**Miles Briggs**	**Strong support**
Amendment #257	**Fulton MacGregor**	

RCGP Scotland recommends that the Bill be amended for a different service model in the form of a specialised service. We do not believe it is appropriate or practice to sit within the core responsibilities of general practice.

RCGP Scotland advocates for a specialised service for the following reasons:

- **Variation in GP willingness and capacity:** Our member engagement and surveys indicate a large number of GPs would not be willing to participate in assisted dying in any form and therefore expecting that the patient's own GP will participate is unlikely to be the norm. It would not be feasible for an assisted dying service to be simply subsumed into existing general practice contracted services. GPs are currently operating under significant pressure. Some areas, particularly remote and rural areas, are likely to have a majority of (if not all) GPs opting not to take part in any assisted dying related activities.

- **Specialist multidisciplinary approach:** The needs of patients seeking assisted dying will go far beyond assessment and administration of drugs; it must also support the whole person, including their physical, emotional, psychological,

social, and spiritual needs, with adequate time to discuss and meet these needs. Families will also need care, before, during and after a bereavement. Creating a specialist commissioned pathway, with a central network of medical professionals who would form multidisciplinary neighbourhood teams, could be one way to do this.

- **Continuity and coordination:** A standalone service would ensure that patients can be supported consistently throughout their journey by a specialist team, who would coordinate care relating to assisted dying. We would expect that the patient's existing GP (whether they are involved in the specialist service or not) would continue to provide all other non-assisted dying appropriate support to the patient. Patients could also be assigned a named care navigator within the specialist service who could support with administration, connect with other providers as needed and check in regularly on the patient's wellbeing and any evolving needs. This would also help ensure greater continuity of care.

- **Workforce protection:** The time commitment and emotional toll on professionals involved in assisted dying must be acknowledged. A funded standalone service model as outlined above would allow for protected time, high quality mandatory training, and psychological support for staff.

- **Service feasibility and expertise:** Based on the Bill's estimated uptake, most GPs would only very occasionally be called upon to engage in an assisted dying process, meaning they would likely find it challenging to develop the necessary skills and confidence, as they would not be participating on a regular basis. A specialist activity of this type should not be part of the core part of general practice work and should instead be handled a national or Health Board level commissioned specialist service.

It is important to clarify that a specialised service as outlined above would not necessarily need to be conducted in new / separate physical buildings to existing NHS services. These services could be community-based, close to home, or at home, with a dedicated team they could get to know and trust, and who would provide continuity of care during the process. Where possible, an individual's wish to die could include a death at home, surrounded by loved ones if requested, or in a hospice setting.

If you have any further questions, please contact Caroline Hickling, Policy & Public Affairs Manager: caroline.hickling@rcgp.org.uk / 07741669325