RCGP SCOTLAND

Stage 3 - 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

Issues of legislative competence: removal of critical safeguards

RCGP Scotland is hugely concerned that sections of the Bill containing fundamental safeguards are to be removed by amendment at Stage 3, to be considered under a future section 104 Order, in order to assure the Bill is within the legislative competence of the Scottish Parliament.

Of key concern is section 18 of the Bill, which contains fundamental protections that would ensure healthcare professionals are able to actively choose if they participate in providing the assisted dying service, without fear that doing so could affect their employment, career progression or regulatory standing. Similarly affected are sections related to training, qualifications and experience for the different roles set out by the Bill.

These measures are critical for patients and healthcare professionals alike and must be in the Act.

While Section 104 Orders are made as a consequence of an Act of the Scottish Parliament, the Section 30 Order being applied to the specification of approved substances has been considered in advance.

While we have sought reassurance and clarity around what a future section 104 Order will cover, ultimately a section 104 Order will be for the UK Government to lay before the UK Parliament. We recognise that the Scottish Government would continue to work closely with the UK Government, should the Bill pass, to seek agreement on the final content of such an Order.

Our members have been in touch to express their concern that these key professional protections would be taken out of the Bill entirely and shifted to secondary legislation that receives only limited parliamentary scrutiny.

RCGP Scotland has repeatedly expressed that robust statutory safeguards are non-negotiable for any Bill to legalise assisted dying. The robustness and transparency of the legislative process for a Bill of this magnitude must be beyond reproach.

While the RCGP has no position on the legalisation of assisted dying in principle and remains open to considering future proposals, we would oppose any construction of assisted dying that did not ensure protection for GPs who want, and do not want to participate.

Stage 3 amendments

Key amendments have been tabled at Stage 3 which go some way to meet our principles for assisted dying legislation.

RCGP Scotland strongly supports these amendments and urges MSPs to vote for the amendments to be incorporated into the Bill.

Provision of the service

Amendment #250	**Fulton MacGregor MSP**	**Strong support**

RCGP Scotland urges MSPs to amend the Bill so that any assisted dying provision is delivered through a standalone specialised service. We do not believe it is appropriate or practice to sit within the core responsibilities of general practice. Patients deserve nothing less than the highest level of clinical expertise and support at one of the most vulnerable points in their lives.

The complexity of providing this new service demands concentrated expertise and experience. A specialised, opt-in service would allow trained clinicians to develop the depth of knowledge, confidence, and professional resilience required for this sensitive work, ensuring patients receive care from teams who are genuinely equipped for the task.

Embedding this model on the face of the Bill is essential for Parliament to guarantee a safe, ethically robust, and patient-centred approach that reflects both the gravity of the decision and the needs of the people of Scotland.

It is important to clarify that a specialised service as outlined above would not be outwith the NHS or necessarily need to be conducted in new / separate physical buildings to existing NHS services. These services would be community-based, close to home or at home, with a dedicated team that patients could get to know and trust, and who would provide continuity of care during the process.

On behalf of patients and GPs, 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 less populated areas may have a majority of GPs opting not to take part in any assisted dying related activities. A specialised, separate service would ensure patients do not suffer from a postcode lottery.

- **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 bereavement. Creating a commissioned pathway for patients, with a central network of medical professionals forming multidisciplinary teams, would 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 team, who would coordinate care relating to assisted dying and respond to a patient's evolving needs. 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.

- **Workforce protection:** The time commitment and emotional toll on professionals involved in assisted dying must be acknowledged. A service model as outlined above would encapsulate critical protections: 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 on 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 general practice work and should instead be handled by a commissioned specialised service, so that the patient receives immediate, confident support from the beginning of their journey.

- It is reasonable to expect higher costs for a dedicated specialist service; however, for a decision with such profound implications for patients, RCGP Scotland does not accept cost as an argument against creating a safe, expert-led model.

Provision of the service

Amendment #263 Miles Briggs MSP Strongly support

Similarly, we urge MSPs to support #263 in the name of Miles Briggs. This amendment would ensure that the guidance prepared and published by Scottish Ministers would include how the provision of the service should be arranged by Health Boards, including the development of patient pathways.

This too would ensure more consistent patient experience, clearer expectations for Health Boards, and supports effective implementation. Making patient pathway development a required part of the guidance would help ensure clarity for patients and a smoother process.

Register of persons willing to carry out functions under the Act

Amendment #142 Miles Briggs 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 welcomed amendments from Liam McArthur MSP at Stage 2 to ensure that healthcare professionals were under no duty to participate in the assisted dying service if the Bill passes, and the removal of the need to prove grounds of conscientious objection. We note that this section is now subject to the Section 104 Order.

This amendment enhances that protection of choice by requiring Ministers to establish a register of staff who have opted in to carry out the functions of the assisted dying service. It states that a person may only be included in the register if they have opted in, obtained the required qualifications and experience, and are willing to carry out the role or roles to which they would be registered.

The amendment explicitly puts 'opted-in' onto the face of the Bill. Our GP members report 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 a number of benefits to this proposal:

- 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.
- This would also ensure high-quality patient care and experience.
- 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.
- It would also make it easier for the coordinating Registered Medical Practitioner to identify someone to fulfil the role of independent Registered Medical Practitioner and, if required, an Authorised Health Professional.
- It would make it easier for health professionals to direct a patient to a doctor who would fulfil the role of cRMP.
- It would also allow Health Boards to accurately map the staff available locally to provide assisted dying.

Training requirements

Amendment #147 Miles Briggs MSP Strongly support

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.

Amendment #147 further requires Ministers to specify minimum training standards, including but not limited to:

(i) assessing capacity and coercion,
(ii) understanding prognostic uncertainty,
(iii) rare and fluctuating conditions,
(iv) communicating with families and carers,
(v) pathways for palliative and home-based care,

It requires training standards be developed in consultation with such persons as the Chief Medical Officer considers appropriate and reviewed every three years.

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 to provide the highest quality service for patients.

We recommend that MSPs vote against the following amendments:

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

Amendment #235	**Jeremy Balfour MSP**	**Oppose**
Amendment #18	**Daniel Johnson MSP**	
Amendment #19		

We would encourage MSPs to oppose amendments #235, #18, and #19. These amendments would prohibit a registered medical practitioner from initiating, raising, proposing or otherwise introducing the subject of the provision of assisted dying with a person.

At Stage 2, RCGP Scotland was pleased to see amendments accepted to make it 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.

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