Scottish Partnership for Palliative Care

# Assisted Dying for Terminally Ill Adults (Scotland) Bill

## Listing of All Changes to the Bill at Stage 2

### Definition of terminal illness

- Clause added that a person is not terminally ill only because they have a disability or a mental disorder.
- Clause added to define mental disorder (by reference to Mental Health Act (2003)

### Eligibility

- Minimum age raised from 16 to 18 years (and this is reflected in a change to the forms documenting eligibility).

### Training for co-ordinating registered medical practitioners (CRMP) and independent registered medical practitioners (IRMP)

(there are 2 doctors involved the lead one (CRMP) and independent one (IRMP) who essentially repeats the assessment after the CRMP). RMPs used here sometimes to indicate both roles).

- Language strengthened so that SG MUST specify by regulations the training required for these roles.

### Duty to direct

- A new section with a couple of clauses requires that where a medical practitioner is approached by someone seeking AD, but the practitioner is unable or unwilling act as the CMP they must either:
    - Direct the person to another doctor who may be willing to be the CMP or/
    - Direct the person to information about AD in Scotland

## Medical practitioners' assessments

- A clause added such that the assessments must include ascertaining where the person seeking AD has been provided with, or offered, appropriate social care relevant to the terminal illness
- RMPs must make enquiries of professionals currently or recently providing health/social care to the person requesting AD (in so far as the RMP considers appropriate)
- RMPs must inform the person seeking AD "that they can be referred for a palliative care assessment to explore whether any additional support could be provided to them"
- RMPs must consider making enquiries of health, social care or social work professional with qualifications or experience of something relevant to the person being assessed
- Broadening of the things the RMP must explain and discuss (alongside palliative care) to include hospice or other care, including symptom management and psychological support.
- RMPs must "enquire about and discuss the person's reasons for wishing to be lawfully provided with assistance to end their own life".
- RMPs must inform the person seeking AD that they may be referred for a social work assessment (and explain any potential benefits of such an assessment). *But there is a strange cross reference to* "subsection (4)(a)" *which doesn't seem to exist/make sense*
- Where the RMP has any doubt about the capacity of a person seeking AD they MUST refer the person to a specialist. (previously the Bill said "MAY refer").
- Where the RMP has any doubt about whether the person seeking AD is "terminally ill" they MUST refer the person to a specialist. (previously the Bill said "MAY refer").

## Signing by a proxy

- Instead of only advocates, solicitors and JPs being able to act as a proxy, the Bill now allows any adult who has known the person for 2 years, or who meets a description (to be specified in SG regulations).

## Right to advocacy

- A whole new section (14) granting a legal right of access to independent advocacy services to anyone considering requesting AD who "requires an advocate's help to effectively and safely request that assistance and with the process leading up to provision of that assistance".

- A subsection requires SG to set standards for such independent advocacy services

## Provision of assistance (to shorten life)

- A clause requiring that the lethal meds must be provided to the RMP (or an authorized healthcare professional they have delegated to) by a registered pharmacist
- A nurse has to be accompanied by a doctor when providing the lethal meds (previously it could have been a lone nurse)
- A doctor has to confirm immediately prior to providing the lethal meds that the person has capacity and is acting voluntarily without coercion (previously this may have been left to a nurse)
- A clause stating that "for the avoidance of doubt, nothing in this section authorises any person to administer an approved substance to the adult on their behalf with the intention of bringing about the adult's death".
- A clause setting out the sorts of assistance which the CMP may provide: preparing the substance for use; preparing a medical device which can be used to self-administer; help the person to ingest or otherwise use the substance. A subsequent clause saying that none of this assistance must prevent the final decision and act of using the lethal substance being taken by the person. And a clause saying that a nurse must be accompanied by another health professional if providing this assistance.
- A clause allowing the RMP (or authorized health professional) not stay in the same room as the person once they have used the substance (but they must "remain with the adult", presumably nearby, until they have died).
- A clause requiring that CRMP must record and report to PHS any complications, adverse reactions, or unintended consequences arising from the lethal meds.
- A clause requiring SG to produce regulations on the training, qualifications and experience required of the "authorized health profession" to whom the CRMP may delegate aspects of the provision of assistance.
- A clause requiring SG to consult before producing these regulations (and also regulations specifying the "approved substance").

## Death certification

- The terminal illness is to be recorded as the direct cause of death (as previously in the Bill) but a new clause requires that "the use of the approved substance" is to be recorded as "other relevant medical information"

## Conscientious objection

The amendments here are a bit confusing (and possibly not internally consistent).

The first clause in this section has been changed as follows "An individual is not under any duty (whether arising from any statutory or other legal requirement) to participate directly in anything authorised by this Act ~~to which that individual has a conscientious objection "~~. So no need to justify non-participation by virtue of belief/conscience. However, there are then 3 subsequent amendments which essentially require that a person not participating must not be subject to any detriment by virtue of their not participating. Two of these non-detriment clauses make reference to non-participation due to conscience. This looks like it will need to be clarified at Stage 3, probably by deleting all clauses with reference to conscience.

## No duty to raise assisted dying

- A new clause stating that no medical practitioner is under any duty to raise the subject of AD with a person
- A new clause stating that nothing in the previous clause prevents a medical practitioner raising the subject if they judge it to be "appropriate" to discuss it with a person (but see below for people aged under 18)
- Health professionals must not raise the subject of AD with a person under 18 unless it has first been raised by the person themselves (either with that professional or another one previously).
- Provision of AD must not be part of an anticipatory care plan (sic) for anyone under 18.

## Provision of assistance outwith the NHS

A new section:

- SG must consult and then develop regulations about the provision of AD outside the NHS including
    - The role of HIS and Care Inspectorate
    - Any settings or services where AD must not be provided

## Offences

- A new offence of coercing or pressuring a person into using a lethal substance (previously the only offence was coercing a person to make a first or second Declaration of intent to pursue AD)
- A new offence of advertising AD (to promote, encourage or solicit the provision of AD to a person) punishable by a fine or max 2-year imprisonment. An associated

clause seeks to ensure the advertising ban doesn't impinge on the provision of information for professionals or the public.

## Assessment of likely impact of Act on palliative and end of life care services

A new section:

- As soon as the Bill becomes law SG must carry out an assessment of, and publish a report on, the likely impact of the law on hospices and providers of palliative care services including effects on:
    - Staffing, including training and support required
    - Operation of existing services
    - Existing funding streams
    - Regulation and scrutiny of palliative and end of life care

## Code of practice on interaction with palliative and end of life care services

Another new section.

- After publishing the impact assessment report mentioned above SG must consult and prepare a code of practice on the interaction between provision of AD and the support provided by hospices and providers of palliative and end of life care. The code of practice must cover:
    - Guidance, training and support to health and social care professionals providing hospice, palliative and end of life care (including staff of non-statutory providers)
    - Any measures to impact any adverse impacts on existing palliative and end of life care services
    - How existing and future statutory funding streams intended to support palliative care services can be differentiated to ensure that AD is not funded at the expense of existing palliative care services
    - How provisions in any AD Act interact with existing regulation and scrutiny of palliative care services

## Guidance

This section lists all the areas of SG Guidance associated with the Bill.

- All the guidance listed MUST be developed (previously "may")
- New requirement to produce guidance on training and quality assurance to ensure "the effective implementation of the Act"

- For all the guidance listed SG must consult trades unions and professional bodies representing people who may carry out functions under the Act (and anyone else they think appropriate)
- A new clause requiring that guidance of the kind mentioned in subsection (2)(g) must be developed with and approved by the Lord Advocate's office. *But that subsection doesn't exist because the amendment creating it was rejected!* It would have been guidance on where the legal and professional accountability lies for AD.

## Duty to provide information

A new Section:

- SG must ensure information about AD in forms accessible to and understandable by:
    - Terminally ill adults wanting AD
    - Health and social care professionals
    - The general public

## Regulation-making powers

There are two ways SG can make regulations. The "negative procedure" essentially involves little scrutiny. The "affirmative procedure" enables a bit more scrutiny. The revised Bill requires the following:

| Topic of Regulations | Affirmative procedure | Negative Procedure |
|---|---|---|
| Training, qualifications and experience of CRMPs, IRMPs and "authorized health professionals" | ✓ (initial regulations only) | |
| Independent advocacy service standards | ✓ | |
| Specifying an approved substance | ✓ | |
| Information which must be provided to Public Health Scotland for their annual reports on AD | ✓ | |
| Incidental minor tweaks to the Act | ✓ | |
| Forms of identity which can be used to comply with Act | | ✓ |
| Description of person who can be a proxy | | ✓ |
| Tweaks to the scope of data PHS must provide in their reports to ministers | | ✓ |

| | | |
|---|---|---|
| Changes to the “Statements” – the forms used to record the AD process completed by CRMP | | ✓ |

## Commencement of the Act

- A new requirement that the ACT can’t come into effect until arrangements for people to access for independent advocacy are in place