End of Life Assistance (Scotland) Bill

Mental Welfare Commission for Scotland

The Commission is grateful for the opportunity to comment on the Bill. Our primary focus is on the rights and welfare of people with mental disorder and we wish to ensure that nothing within the Bill threatens these.

Overall, there are mixed views within the Commission about the Bill. We recognise the suffering of people with illnesses that are progressive and disabling. We wish to see high quality palliative care services in place across Scotland. We have looked into palliative care for people with dementia and have had some concerns at times. People with dementia will not be able to request “end of life assistance” and we would not be in favour of any procedure for them either to request this in advance or to give this authority to a welfare attorney. We wish to emphasise the importance of palliative care for this group of people.

We restrict our comments to the safeguards within the Bill. It is important to guard against a person requesting end-of-life assistance where there may be a treatable mental disorder and/or where the person’s capacity may be diminished.

We note that there must be two formal requests and that each request must be considered by the designated practitioner. Each request also triggers a psychiatric examination. We wish to make the following points in relation to these requests and examinations.

1. We note that, although the person must be registered with a medical practice in Scotland for 18 months, there is no role for a medical practitioner from that practice within the Bill. The “designated practitioner” appears to be any registered medical practitioner. The risk is that a small number of medical practitioners with a particular belief in “end-of-life assistance” could in theory undertake a significant amount of work without enough independent safeguards.
2. There is no requirement for the designated practitioner to consult with, or receive a report from the person’s general medical practitioner or a specialist in the palliative care of the condition from which the person suffers. These appear to be serious omissions.
3. “Designated practitioner” could be confused with the term “designated medical practitioner” under part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 – a completely different role.
4. There is a requirement for two psychiatric examinations in terms of section 9 of the Bill. Our comments about designated practitioners also apply to psychiatrists – we are not convinced that this is a sufficient safeguard. As the Bill stands, only one psychiatrist need be involved. That psychiatrist could perform both examinations. The psychiatrist could come from any branch of the profession. While psychiatrists can competently diagnose, for example, major depression, the diagnosis
and management of depressions in people who are seriously physically ill is more specialised. We think there would need to be greater consideration of the independence and expertise of the psychiatrists. We also advise that the psychiatric examination relating to the second request should not be from the psychiatrist that examined the person after the first request.

5. The Committee may wish to consider the approach taken where a person is being considered for neurosurgery for mental disorder. We draw the Committee's attention to section 235 of that Act that specifies the safeguards for any patient consenting to neurosurgery:

235 Treatment mentioned in section 234(2): patients capable of consenting
(1) Medical treatment mentioned in section 234(2) of this Act is given to a patient in accordance with this section if the requirements set out in subsections (2) and (3) below are satisfied.
(2) Subject to subsection (6) below, the first requirement is that a designated medical practitioner who is not the patient's responsible medical officer certifies in writing that—
   (a) the patient is capable of consenting to the treatment;
   (b) the patient consents in writing to the treatment; and
   (c) having regard to the likelihood of its alleviating, or preventing a deterioration in, the patient's condition, it is in the patient's best interests that the treatment should be given to the patient.
(3) The second requirement is that two other persons (not being medical practitioners) appointed by the Commission for the purposes of this subsection certify in writing that—
   (a) the patient is capable of consenting to the treatment; and
   (b) the patient consents in writing to the treatment.
(4) A person appointed for the purposes of subsection (3) above may—
   (a) interview the patient at any reasonable time; and
   (b) require any such interview to be conducted in private.
(5) If the patient withdraws consent to the treatment (in writing or otherwise) at any time before its completion, this section shall then apply as if the remainder of the treatment were a separate treatment.
(6) Where—
   (a) the patient is a child; and
   (b) the patient's responsible medical officer is not a child specialist,
the first requirement is that the matters mentioned in paragraphs (a) to (c) of subsection (2) above are certified in writing by a designated medical practitioner who is a child specialist.
(7) References in subsections (2) and (6)(b) above to a patient's responsible medical officer include, in any case where a patient does not have a responsible medical officer, references to the medical practitioner primarily responsible for treating the patient.

There may be the basis here of an appropriate model that provides greater safeguards than the Bill (as introduced) contains. In particular, the introduction of a non-medical view, not merely as a witness but as a person giving testimony to capacity should be considered. Also, the independence of the Commission is essential here. We appoint and train
designated medical practitioners and others involved in the assessment. The Bill contains no external check or regulation of the medical opinions. This causes us significant anxiety and we strongly advice the Committee to address this if the Bill makes further progress. We do not consider this to be an appropriate role for the Mental Welfare Commission. There would need to be a new independent safeguarding function for this and such a function would have cost implications for the Bill.

We hope these comments are helpful to the Committee.

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