End of Life Assistance (Scotland) Bill

Royal College of Psychiatrists

Dr Stephen Potts was asked by the Scottish Division of the Royal College of Psychiatrists to respond formally to this Bill on our behalf. He has solicited comments from psychiatrists working across Scotland, and received replies from 25, all of them consultants.

The response has been restricted to the provisions of the Bill which make specific reference to the role envisaged for psychiatrists. As doctors, citizens, taxpayers, carers, and indeed potential patients, psychiatrists are free to respond separately to other specific aspects of the Bill, and to the Bill as a whole, either as individuals, or through other organisations.

Dr Potts is prepared to offer oral evidence if the committee might find it helpful.

1. Definition of “psychiatrist”

Although it makes repeated reference to assessments by “a psychiatrist”, and sets out what such assessments are expected to cover, the Bill fails to specify the term further. Additional minimum criteria are required, to ensure that psychiatrists undertaking this work are suitably trained and experienced. These criteria might include some or all of the following:

a. Full GMC registration.
b. A specified period of experience in relevant subspecialities, such as old age or liaison psychiatry.
c. Membership of the Royal College of Psychiatrists
d. Approved Medical Practioner (AMP) status, under section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003.
e. Possession of a certificate of completion of specialist training
f. A current contract as a consultant psychiatrist, perhaps in one of a specified set of subspecialities.
g. Fellowship of the Royal College of Psychiatrists.

Recommendation:
As a minimum, the term “psychiatrist” should be understood to imply Membership of the Royal College of Psychiatrists and AMP status. Consideration should be given to restricting it further to imply, in addition, possession of a certificate of completion of specialist training.

2. Oversight arrangements

A number of respondents identified the possibility of “assisted suicide enthusiasts” acting without adequate supervision – and precedents exist, not least in the form of Dr Kevorkian in the USA. The Bill requires that deaths are reported post hoc to the Procurator Fiscal (PF), but the PF has insufficient powers of oversight where criminal offences have not been committed, and
any such powers are retroactive. They may therefore be inadequate to prevent a psychiatrist working in this area unsupervised.

The requirements of clinical governance, appraisal and professional revalidation apply to all areas of clinical practice, and should therefore extend to this area of work. Psychiatrists undertaking these assessments would need to be able to demonstrate formally that they have acquired, and still maintain, the appropriate skills, experience and training. Arrangements need to be in place to ensure that their work is discharged to a sufficient standard, and that any deficits in the standard of the work can be identified and acted on.

Recommendation:
Psychiatrists who choose to undertake this work should ensure that it is covered in the arrangements for appraisal and clinical governance applying to other areas of their practice. Appraisers should be able to opt out of appraisal of this area of practice if they choose: but adequate alternative arrangements must be agreed between the psychiatrist and his or her appraiser.

3 Opting out
The Bill’s explanatory notes specify that the medical practitioner to whom the formal request for end-of-life assistance is made may opt out for reasons of conscience, though it is expected that he or she would refer to another doctor who would be prepared to act on such a request. Neither the Bill nor the explanatory notes make any such statement in relation to the psychiatrist expected to undertake the assessments.

A considerable number of responding psychiatrists voiced concern about this, and argued strongly that there should be no expectation that such work could ever become a duty: in other words there must be an “opt-out” for psychiatrists too.

Since patients eligible for end-of-life assistance are by definition terminally ill, or have incapacitating medical conditions, the psychiatrists most likely to be asked to see them are probably those working in liaison psychiatry - the small sub-speciality dealing with patients in medical and surgical settings. Informal polling of the 27 consultant psychiatrists currently working in this field in Scotland, found that ten out of the sixteen who responded (i.e. 63%) would wish to opt out of some or all of these assessments.

This potentially leaves a very small pool of psychiatrists prepared to take on the work, thereby causing difficulties for those patients who need psychiatrist assessments, and increasing the burden on those who are prepared to offer them. It also raises the possibility that there will be large areas of Scotland where there is no psychiatrist prepared to undertake end of life assistance assessments.

Recommendations:
A specific “opt-out” possibility for psychiatrists expected to undertake these assessments should be written into the Bill. There should be no requirement
on psychiatrists to justify their wish to opt out. A simple expression of preference should be enough.

Consideration should be given to establishing a central register of psychiatrists prepared to undertake these assessments, analogous to the list of ‘second opinion’ psychiatrists held by the Mental Welfare Commission for specific aspects of Mental Health Act work.

4 Age cut-off
The age of eligibility has been set at 16. This is consistent with the definition of “adult” used in the Adults with Incapacity Act (2000). However, other legislation covering psychiatric practice, namely the Mental Health (Care and Treatment) (Scotland) Act 2003 requires Heath Boards to provide “age-appropriate” mental health services for those under 18. If follows that psychiatrists expected to undertake assessments in 16- and 17-year olds seeking end of life assistance would need to be specifically trained in adolescent mental health. Most of Scotland has no psychiatric service at all for adolescents in general hospital settings, and if those few specialists providing it opt out, there will be no age-appropriate and clinically aligned psychiatric assessment available anywhere in the country.

Recommendation:
For this reason alone - as well as a general reluctance amongst respondents to contemplate end of life assistance in young people - the age limit should be revised to 18.

5. Potential for discrimination
At section 4 (2), the eligibility criteria specify that the requesting person must either be terminally ill1 or permanently physically incapacitated to such an extent as not to be able to live independently and finding life intolerable.

Some mental disorders can be as permanent and as incapacitating as physical illness. Psychiatrists cannot support legislation which has the potential for discriminating against those with mental as opposed to physical disorder, by limiting their eligibility for interventions available to the physical ill. It does not follow that psychiatrists would support offering end-of-life assistance to those with mental but not physical disorder, however.

6. Assessing dependence and intolerability
The eligibility criteria referred to above are not further defined. Judging a patient’s ability to live independently is not specifically a psychiatric matter2, but the Bill’s accompanying explanatory notes make it clear that assessing psychiatrists are expected to discuss the degree to which the requesting person finds life intolerable. This sets up a tension. If the judgement of

1 Defined as suffering a progressive condition, which is reasonably expected to cause death within six months. Assessing life expectancy is notoriously prone to error.
2 Though questions still apply: who judges it? On what criteria? Independent of what level of support?
intolerability is purely subjective on the part of the requesting person, what
need is there for a psychiatrist to discuss it? Any more objective view of
intolerability requires criteria against which to judge it. None are presently
available, and there is nothing to suggest that psychiatrists are better placed
than other clinicians to operate them if they were.

Several respondents pointed out a further, very uncomfortable, dichotomy.
From the start of their training, psychiatrists are taught to assess patients for
views such as “life is intolerable” or “I’d be better off dead”: to see them as
symptoms - amongst others - of depressive illness; to recognise their
association with a heightened risk of suicide: and to do everything possible to
reduce that risk, including, where necessary, compulsory admission to
hospital and treatment against a patient’s will. Psychiatrists, for whom this is
their core business, may now also be required under this Bill to assess
someone who clearly and consistently states that life is intolerable and he’d
be better off dead; and to provide a report which then leads to that person
receiving assistance in dying.

This wide divergence in outcome boils down to this: where someone wishing
to die has a mental disorder, psychiatrists will try to keep him alive,
sometimes against his will. Where he has a physical disorder, this Bill expects
psychiatrists to assist in the process of shortening his life.

Recommendation:
If the judgment of intolerability is to be left entirely to the requesting person,
then the Bill or its explanatory notes need to say so, and there should be no
expectation of psychiatric assessment: If it is intended that there should be a
more objective assessment of intolerability, criteria need to be developed
against which to judge it. This judgment too should not form part of any
psychiatric assessment.

7 Assessing mental disorder and capacity
Diagnosing and treating mental disorder is the stock in trade of psychiatry as
a whole. Assessing mental disorder in the physically ill is sometimes more
difficult, but is nonetheless the stock in trade of liaison psychiatry. Assessing
the extent to which the decisions a patient makes are influenced by mental
disorder can also be difficult, but is part of the daily practice of psychiatrists in
all fields, and is explicitly required in the relevant provisions of mental health
and incapacity legislation. Respondents recognised all this, and agreed that
psychiatric assessments under the Bill may have something to offer, in these
contexts if no other.

However, many respondents raised the concern that the Bill also assigns to
psychiatrists the assessment of capacity in requesting persons without mental
disorder. As the Adults with Incapacity Act 2000 and its associated Code of
Practice make very clear, assessing capacity is intended to be a generic
responsibility of clinicians in all areas. Where it is a matter of assessing
capacity to consent to (or decline) specific medical or surgical treatments,
then the responsibility for assessing capacity falls on the doctor primarily
responsible for the treatment in question – in this case the doctor offering end
of-life assistance. The Act and its Code also make it clear that there is a general presumption of capacity: in other words all adults are presumed to have capacity for all decisions, until proven otherwise; and the burden of proof falls on those who would deny it.

The Bill reverses these presumptions, so that there is no presumption of capacity in persons seeking end of life assistance: instead they are to undergo psychiatric assessment, where the burden of proof falls on the psychiatrist to declare that they have capacity: and the psychiatrist is expected to do so even when there is no question of mental disorder. There was a general reluctance amongst respondents to accept these responsibilities, at least in these terms.

In section 9, the Bill requires that as part of the assessment of capacity, the psychiatrist and the requesting person should discuss: the medical condition giving rise to the request; all feasible alternatives to end of life assistance, including hospice care and palliative care; and the forms of end of life assistance which may be provided. This presumes a degree of knowledge which neither the psychiatrist nor the requesting person may possess. To be valid, assessment of this element of capacity can only be undertaken by a doctor who is herself fully informed on these matters; an expertise which is not normally part of a psychiatrist’s skill set. The assessing doctor must also be able to judge whether the amount and type of information provided to the requesting person by his treating doctors is sufficient and appropriate. Again, this is not a matter on which psychiatrists are qualified to pronounce.

The Bill is silent on how to proceed if psychiatric assessment identifies hitherto undiagnosed mental disorder. Does the assessing psychiatrist acquire a responsibility to treat, it or ensure it is treated? What if the requesting person disagrees, or declines the offer of treatment?

**Recommendation:**
While psychiatrists can assist with assessments of capacity, they should not be assigned the primary role. They can report on the presence or absence of mental disorder, and the extent to which decision making is influenced by any mental disorder that is present. They should not be expected to report on capacity beyond this.

### 8 Assessing “undue influence”
Section 9 also requires the assessing psychiatrist to report on whether the requesting person is acting under “undue influence” (i.e. coercion). In contrast to the elements of capacity outlined above, psychiatrists have nothing to offer in assessing coercion. It is not a psychiatric skill, and forms little or no part of psychiatric practice.

Many respondents made this point, stressing the difficulty of assessing undue influence in one-off assessment. Such judgements would more appropriately be made by the general practitioner or treating hospital specialist on the basis
of their long-standing knowledge of the requesting person, their family situation, and their response so far to their illness and its treatment.

**Recommendation:**
Undue influence or coercion clearly needs to be assessed: but it should not fall to a psychiatrist to make this judgement.

**9 Second assessment and appeals**
The Bill allows that the same psychiatrist could undertake the two assessments required. Of those respondents who addressed this point, all were clear that the assessments should be undertaken by two different psychiatrists. One respondent stressed the need for an appeals procedure (akin to that in the Adults with Incapacity Act) to resolve differences of view between the requesting person and the various professionals involved.

**Recommendation:**
If the Act specifies a requirement for two separate psychiatric assessments, it needs to further specify that two different psychiatrists should undertake them. Consideration should be given to building in an appeals procedure.

Though the parallel may at first appear distant, those parts of this legislation which govern the assessment of live organ donors repay study. When this Act came into force in 2006, it extended considerably the range of transplants from living donors that could be lawfully undertaken across the UK. More relevantly, it laid down new procedures for careful assessment of living donors.

The Act established the Human Tissue Authority, which trains, appoints and oversees Independent Assessors (IAs). IAs are usually, but not always, doctors in areas of hospital practice other than transplantation. Some IAs are nurse consultants, doctors in laboratory specialities, or hospital chaplains. A few are psychiatrists. There are approximately ten IAs working in Scotland, each seeing between 5 and 10 cases per year.

The IA is expected to meet the potential donor and recipient, as the last step before a date is set for surgery. They are provided with all relevant information, including, where necessary, a psychiatric report, (which is obligatory for “non-directed” or “altruistic” transplants).

The IA is expected to report on the donor’s understanding and acceptance of the medical risks and other consequences of donation, and their capacity to make such a decision.

The IA is also expected to provide evidence that the donor is not subject to any coercion or incentive. This part of the IA assessment is probably the most difficult; but it is not impossible. Through his own work as an IA, Dr Potts is aware of three cases where transplant did not proceed because of concerns about undue influence. Dr Potts is also aware of a case where transplant did
proceed, but failed, and where the recipient subsequently complained that he had been pressurised by a relative into receiving his organ.

**Recommendation:**
The Committee should examine the workings of relevant parts of the Human Tissue Act and associated Codes of Practice, to draw lessons that could be transferred to the field of end-of-life assistance.

**CONCLUSION:**
For the reasons set out above, the Bill, in its current form, does not command the support of the Scottish Division of the Royal College of Psychiatrists, the professional body representing those who would be expected to undertake the psychiatric assessments the Bill specifies.

A substantial proportion (and possibly a majority) of the psychiatrists to whom these assessments would fall, would seek to opt out from participation in the end-of-life assistance process as currently proposed in the Bill.

Amendments which address the concerns listed might reduce opposition to the Bill amongst psychiatrists, both as individuals and as a professional group.

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