Overall position on the Bill

- **The RCN has a neutral position on whether the law on assisted dying should be changed**, reflecting our members' differing views on the issue.
- But this does not mean we're silent, the Scottish Bill includes a key role for registered nurses (which is different to the UK Bill).
- We therefore have a responsibility to ensure the Bill contains the necessary safeguards to protect nurses and nursing practice.
- We are working to protect both nurses who may wish to participate in assisting a death under the framework established by the Bill, and those who may not wish to participate.
- **Notwithstanding our neutral position on whether assisted dying should be legalised, our position is that the Bill does not sufficiently protect nursing staff.**
- Amendments are needed to the Bill to ensure that, if it is passed by MSPs, nurses are adequately protected.
- As well as protecting our individual members, we are also mindful of the need to ensure that, if the Bill passes, it results in a high-quality service which does not have a negative resourcing impact on existing, and often struggling, nursing services.

What impact will the Bill have on nurses?

- The Bill establishes the role of the "authorised health professional" (AuHP) who, on the day of the assisted death, may provide an eligible individual with an approved substance which they will take to end their life. Registered nurses can take on the role of AuHP if authorised by the doctor who is coordinating the process.
- This is a different approach to the UK Bill, which provides that only the coordinating doctor, or another doctor they authorise, may provide assistance.
- When acting as an AuHP, a registered nurse would be required to undertake a final assessment of the individual's capacity and be satisfied that they have not been coerced, before providing the individual with the substance. Again, this is a role that would be undertaken by a doctor under the UK Bill.
- Once satisfied that the individual has capacity and is acting voluntarily, the registered nurse would provide the individual with the approved substance and remain with them until they decide whether to use it and, if so, until the individual has died.
- The Bill contains a clause stating that no individual is under any duty to participate in anything authorised by the legislation to which they have a conscientious objection.
- Providing someone with assistance to end their life will require time, in order to provide individuals, and their families, with the necessary care, support and respect. Therefore, in practice, it is likely that registered nurses will in most cases take on this role. Liam McArthur MSP has acknowledged this point when he highlighted that in Australia, over time, nurses have tended to become increasingly involved in the process instead of doctors.

- While the creation of the AuHP role is the most explicit way the Bill will impact registered nurses, we can envisage other ways the legislation will impact nursing roles. For example, nurses may be asked to accompany a doctor when providing assistance, in order to provide end of life care, or may be asked to take on a role coordinating the provision of services locally.

What roles will be impacted?

- Beyond establishing the legal framework, the Bill is largely silent on how assisted dying would be delivered in practice. But accompanying documents suggest it would involve the patient's own GP, or specialist doctor, as part of their standard care and treatment.
- If we assume a similar approach for nursing to that envisaged for doctors' involvement, then registered nurses working in a wide range of settings, for example district nursing, GP practices, hospices, social care and acute medical settings, could be expected to take on the role of AuHP.
- The Bill is silent on the level of experience or qualifications for RNs taking on the role of AuHP, despite being required to make complex assessments around capacity and coercion.

RCN concerns

- If assisted dying is legalised, nurses must have a genuine choice about whether, and if so to what extent, they are willing to participate. The current Bill does not achieve this.
- The conscientious objection clause does not offer sufficient protection for nursing staff who do not wish to participate.
- The Bill requires registered nurses to make complex assessments around capacity and coercion when taking on the role of authorised health professional. This goes beyond the scope of practice of most registered nurses.
- The Bill does not require two health professionals to attend together to provide assistance. Attending alone would leave our members open to accusations of coercion or wrongdoing and represents an unacceptable risk.
- The Bill does not mandate training for healthcare professionals involved, and the financial memorandum gave no consideration to the cost of training nurses.
- We do not support an approach where assisted dying would simply be provided by existing teams, for example district nurses. Expecting existing, overstretched teams to take on this role would not be safe or sustainable.
- We are also concerned that scrutiny of the Bill has so far overlooked the role of nurses, instead focusing on the role of medical practitioners. The role for nurses as authorised health professionals means that attention needs to be paid to ensuring appropriate protections and support, which won't necessarily be the same as those required for doctors.

RCN priorities for amending the Bill at stage 2

The Bill should make clear that an opt-in model will be established:

- The Bill should make clear that an "opt-in" model of delivery is to be established so that only health professionals who positively choose to participate, and who have completed mandatory training, will be expected to do so.
- Establishing an opt-in model would provide a greater degree of choice and reassure nurses who do not wish to participate that they would not be asked to do so.
- It also has the important advantage of ensuring that nurses who agree to participate receive the in-depth training necessary and are deemed competent to provide this complex role. They would build up experience and could receive appropriate wellbeing support.
- NHS Boards would hold the register of staff who have opted in locally, and this would mean that doctors who have not opted in, could simply refer an individual who requests an assisted death.
- 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 training to a much wider cohort of health professionals who may, or may not, be asked to participate in assisting a death at some point.

There should be a general right to refuse to participate in activities directly related to assisted dying:

- Our position is that the conscientious objection clause alone does not offer sufficient protection, and that staff should be able to object to being involved based on conscience or any other reason.
- The Bill places the burden of proof of conscientious objection on the individual health professional. We know that some of our members do not want to be involved for reasons other than conscientious objection. For example, when we surveyed our members in December, a number of members commented that they agree with the principle of assisted dying but would not want to participate in the process as they feel it would have a negative impact on their mental health.
- We are calling for an opt-in provision as a further safeguard. But nurses who do not opt-in to become an authorised health professional may be asked to be directly involved in other ways, for example accompanying a doctor when the substance is provided, and there should be a general right to decline to carry out these roles.

The requirement for nurses to undertake capacity and coercion assessments should be removed:

- We do not support the current provisions (in section 15) requiring a registered nurse, performing the role of authorised health professional, to undertake the final assessments on capacity and coercion before providing the individual with the approved substance. This goes beyond the scope of practice of most registered nurses. There may be some specialist nurses working at advanced practice level whose role involves undertaking assessments of capacity, for example in mental health, but this is not common practice and cannot simply be addressed with a training module.

- A substantial period of time may have elapsed since the first assessment of capacity and coercion which makes this a significant decision. In addition, unlike the first assessment (carried out by a doctor), there is no scope or safeguard for a second opinion.
- **The Bill should be amended to provide that a doctor must undertake the final assessments on capacity and coercion under Section 15.**
- Once the doctor is satisfied that the individual has capacity and is not being coerced, a registered nurse, if authorised by the attending doctor, can immediately dispense, deliver and provide assistance to end a person's life. This is the model that has been agreed in the Isle of Man legislation.

Authorised health professionals should not provide assistance to die while working alone:

- **A key concern is that the Bill allows a nurse to provide a terminally ill adult with an approved substance to end their life while working alone**. While it states that a nurse may be accompanied by another health professional as they think necessary, it does not require this.
- This would leave our members open to accusations of coercion or wrongdoing and represents an unacceptable risk.
- There are various challenging situations that could be faced (for example distressed family members, an individual lacking the ability to self-administer and therefore not being able to receive assistance or an unexpected response to the substance) and we are clear that **the Bill must require an authorised health professional to be accompanied by another registered health professionals when providing assistance.**
- Our member survey was clear that the vast majority of respondents would expect at least two health professionals present when providing the approved substance. The general sense from the comments is that the level of responsibility and agility required is too great for one health professional to undertake alone.

Specialist training must be provided:

- **The Bill should make clear that appropriate, specialist training must be provided to all nurses participating in assisted dying, prior to them being involved in an assisted death**. As discussed above, our position is that **the best way to ensure staff are highly trained is for staff to be required to complete training as part of an opt-in model.**
- Our member survey showed that the overwhelming majority (93%) expected to receive specialist training on all aspects of the role of nursing in relation to assisted dying, before participating in activities directly related to assisted dying.

A clause on qualifications and experience should be introduced:

- The Bill allows Scottish Ministers to specify in regulations any particular qualifications and experience that a doctor should have to perform the role of coordinating medical practitioner or independent registered medical practitioner. The Bill does not include a similar provision for registered nurses taking on the role of authorised health professional.
- **A similar provision should be introduced allowing Ministers to specify in regulations qualifications and experience that a registered nurse should have to take on the role of authorised health professional**.

Model of delivery:

- While the Bill is largely silent on how assisted dying would be delivered if the legislation passes, the accompanying documents suggest that doctors and nurses would take on the roles set out in the Bill as part of their existing employment and that the cost of delivering the assisted dying would be absorbed by existing budgets.
- If the Bill passes, we do not support an approach where assisted dying would simply be provided by existing teams, for example district nurses.
- **The Bill should make clear that assisted dying will be delivered by a specialist NHS workforce that have opted in, with dedicated patient pathways.**
- Providing someone with assistance to end their life will require specialist training and should be provided by individuals who have opted into that role and are able to develop confidence and experience. It also requires time in order to provide individuals, and their families, with the necessary care, support and respect. Expecting existing teams to take on this role, in addition to existing workloads, would not be safe or sustainable.
- **The Bill should also be amended to ensure the provision of assisted dying is rooted within the NHS only.**

Protection from discrimination and harassment:

- **The Bill should be amended to provide statutory protection from discrimination for registered nurses so that it is unlawful to discriminate against them based on their decision to either participate or not participate in assisted dying**. We welcome the Committee's call for the inclusion of a 'no detriment' clause to be investigated at stage 2.
- Assisted dying is an extremely emotive issues, with strongly held views on either side of the debate, and health care staff should not be concerned about whether their decision to participate, or not participate, will have an impact on their professional or personal life. This provision may provide particular reassurance for staff who work in rural areas or in small communities.
- We also support the BMA's calls for the Bill to include provision for safe access zones that could be established in future, should the need arise, to protect staff and patients from harassment.

For further detail about any of these issues please contact the RCN Scotland Policy team by email at PolicyScotland@rcn.org.uk